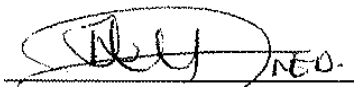
FACTORS INFLUENCING THE RETENTION OF MIDWIVES IN THE PUBLIC SECTOR MATERNITY SERVICES IN JOHANNESBURG

Won-li Richardson

A Dissertation submitted to the Faculty of Health Sciences, University of Witwatersrand, in fulfilment of the requirements for the degree of Master of Science in Nursing.

DECLARATION

I, Won-li Richardson, declare that this Dissertation is my own, unaided work. It is being submitted for the Degree of Master of Science in Nursing at the University of Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other University.



Won-li Richardson

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ABSTRACT

Midwives face workplace challenges potentially leading to high staff turnover and poor retention within maternity care services. High turnover and low retention are associated with staff shortages, which inadvertently affect patient outcomes for mothers and their newborn babies. This study explored the work-life challenges and motivating factors that influence the retention of midwives in maternity services and measured midwives' quality of work-life.

A concurrent mixed method design with a mixed method notation of QUAL+quan was used. The study consisted of two phases that occurred concurrently. In phase one, midwives were selected using non-probability self-selection sampling. In phase two, convenience sampling was used. Both samples consisted of midwives working in maternity services in the public sector of Johannesburg, specifically at Midwives Obstetric Units (MOUs) where midwives work independently. Creswell's six steps were followed to analyse qualitative data from in-depth interviews. Questionnaires based on Brooks' Quality of Nursing Worklife Survey (BQNW) were analysed to yield descriptive statistics. Findings from a scoping review were integrated into the overall analysis of findings with the use of the Conceptual Framework for Predicting Nurse Retention (CFPNR) by Sawatzky and Enns (2012).

Four themes identified in the qualitative data were: motivation to stay; staff shortages; the inner context; and the outer organisational context. The context refers to the institutional or organisational setting. Main findings indicated that midwives are intrinsically motivated to stay in the profession. However, they are predominantly challenged by issues related to perceived staff shortages, an apparent lack of support and resources, and community conflict. All data and scoping review findings consisted of the influencing and intermediary factors of the CFPNR, which in turn impact employees' intention to leave, thus influencing retention of midwives.

Staff shortages increase midwives' current high workload, hinder opportunities for training and are associated with employee burnout. Midwives lack various forms of support, which include assistance from management, doctors and support staff, in addition to debriefing and counselling. Other challenges include inadequate

equipment and resources, as well as community and patient conflict. As a result, an apprehension of litigation is instilled.

Recommendations from the study include that management is to recognise and acknowledge midwives for their work when done well, with the use of frequent appraisals. It is also recommended that the upper manager increase their visibility in the MOUs in order to touch base with midwives on the floor. Furthermore, it is recommended to conduct debriefing sessions with midwives on a regular basis and involve midwives in decisions concerning their off-duties and allocations. During these discussions, training plans for learning and development may be developed in advance.

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CHAPTER ONE: INTRODUCTION AND OVERVIEW

1.1 Introduction and background

Midwives are faced with various challenges on a daily basis. A few of these challenges include having to work in ill-equipped facilities, a lack of supplies, staff shortages and high risk of exposure to infections such as HIV (Yekple, Affram & Donkor, 2014). Despite being faced with these challenges, they still make the decision to remain practising as midwives regardless of unfavourable conditions.

Literature indicated that retention of staff is influenced by factors such as job satisfaction, availability of resources and staff shortages (Mokoka, Ehlers & Oosthuizen, 2011). Furthermore, George, Quinlan, Reardon and Aguilera (2012:6) stated that "the shortage of health care personnel refers primarily to inadequate production, harnessing and retention of appropriately skilled health care personnel". As there is an existing shortage of midwives, it is important to focus on how to retain the remaining and future midwives in the profession. When discussing the retention of midwives, it was noted that current South African midwifery training is often accompanied by initial training as a registered nurse. There was a limited amount of literature specifically related to the retention and related shortage of registered midwives, thus literature related to retention of registered nurses was included.

Retention of staff is exacerbated by staff shortages and vice versa, therefore it was worth noting the implications that staff shortages have. One of the main implications was indicated as poor patient outcomes. In a study conducted in the United States of America (USA) it was found that more than 80% of registered nurses reported that a shortage of nurses negatively impacted the care delivery process. This process included nurses not responding to pages or calls timeously, a high amount of nurse related complaints from patients and staff communication issues (Buerhaus, Donelan, Ulrich, Norman, DesRoches & Dittus, 2007). Moreover, Rosseter (2014) from the American Association of Colleges of Nursing compiled a "Nursing shortage fact sheet", which consulted sixteen different studies that related to the negative impact nursing shortages had on patient care and safety. Furthermore, in the midwifery field, Bremnes, Wiig, Abeid and Darj (2018) mentioned that challenges

encountered by midwives, including staff shortages, hindered the provision of adequate child and maternal health care.

Findings by Lartey, Cummings and Profetto-McGrath (2013) in Canada stated that retaining experienced nurses in the profession not only aided in decreasing workforce shortages, but also enabled increased knowledge sharing among nurses and personnel, leading to improved quality patient care. In order to retain midwives in the profession, a study in Australia found that an enjoyable job, pride in being a midwife and job satisfaction played key roles in increasing retention (Sullivan, Lock & Homer, 2011).

As job satisfaction played a role in the retention of midwives (Sullivan et al., 2011) it was important to note factors that influenced job satisfaction. According to Sinha (2012), it is imperative for an organisation to address employee well-being, as work is a significant setting for many people. Employee well-being influenced job satisfaction, which in turn is related to employee turnover and retention (Wright & Bonett, 2007). When employees perceived their Quality of Work-Life (QWL) in positive regard, a higher level of psychological well-being was noted (Chan & Wyatt, 2007). Thus, improved work-life situations may enhance productivity, commitment and thus retention.

1.1.1 Background in South Africa

In South Africa, 2017 statistics of the South African Nursing Council (SANC) showed that 36% of all persons on the register are Registered Nurses with midwifery qualifications (SANC Registrations and Listed Qualifications, 2018). There is no differentiation in categorising nurses who practice in a general nursing setting as opposed to a midwifery field. Thus, determining how many of these registered nurses were practising as midwives proved difficult. Furthermore, the remainder of nurses were sub-category nurses that work under the direct supervision of registered nurses and midwives. This indicated that less than half of all nurses were able to practice independently. Additionally, the number of practitioners on the register included those who were practising outside of the country. It also did not specify whether Registered nurses/Registered midwives were practising in the private or public sectors.

Tshitangano (2013) mentioned how high turnover and low retention rates of registered nurses in Limpopo, South Africa are impacted by factors related to job dissatisfaction. Factors that were discussed included being content with salaries, feeling safe within the workplace, being provided with opportunities to develop careers and evaluating their organisational missions. Other factors such as quality of care rendered, working hours, supervision in clinical settings, interpersonal relationships in the profession, working autonomously and workplace resource availability were also explored by Tshitangano (2013). Of all the above-mentioned, it was noted that staffing, resources, salaries, workplace safety, career development opportunities and working hours were factors that nurses were the most displeased about.

Conversely, a different study conducted in South Africa identified that irrespective of effective leadership and high levels of job satisfaction, registered nurses still demonstrated the intention to leave their jobs (Sojane, Klopper & Coetzee, 2016). In another study conducted within three African countries, South African participants displayed the lowest levels of job satisfaction and highest turnover intentions. This was despite better resources, better working conditions and more favourable staff ratios (Blaauw, Ditlopo, Maseko, Chirwa, Mwisongo, Bidwell, Thomas & Normand, 2013). However, in all three studies participants included registered nurses, with no specific reference to midwives or practice in the midwifery field.

South African literature also indicated that increased salaries and bonuses played a positive role in the retention of midwives. However, other non-monetary factors were to be addressed in order to enhance retention rates. These factors included management being role models, enhancing nurses' self-esteem by demonstrating respect for them, receiving recognition for exceptional performance and providing opportunities for further training (Mokoka et al., 2011).

Midwives work in a range of private and public health care settings, varying from primary health care to district and tertiary care. The interest of this study was to focus on midwives who worked in Midwives Obstetric Units (MOUs), which are primary health care facilities in the public sector. In these MOUs midwives work independently as opposed to other government or public health care settings where doctors are frequently involved in patient care, such as district and tertiary

institutions. Patients identified with low-risk pregnancies are predominantly cared for by midwives in the public sector.

The retention of midwives in midwifery services needs to be addressed as midwives are involved in all caring aspects of pregnant women and the health of their newborns, thus affecting quality patient care. The focus of this study was to explore and describe the factors that influence midwives to remain in maternity services, irrespective of identified workplace challenges. This was done in order to provide workplace recommendations for midwifery managers, facility managers, Maternal Child health Coordinators, District Health Team and Gauteng Department of Health.

The concept of retention has various meanings, thus for the purpose of the study the following definition by Mokoka et al. (2011) was applied: “an organisation’s ability to keep employees in their positions for as long as possible”. Therefore, in the context of this study, retention was regarded as the effort by management to retain midwives in order to render quality patient care for as long as possible.

1.2 Problem statement

The retention of midwives in South Africa is a concern as the negative implications thereof may exacerbate the existing staff shortage in the public health sector. In turn, this shortage can negatively affect the provision of maternal and child health care (Bremnes et al., 2018). Midwives face workplace challenges every day, which may lead to high staff turnover and poor retention in maternity care services.

Various workplace challenges affecting the retention of midwives were identified (Holland, Tham & Gill, 2018; Curtis, Ball & Kirkham, 2006). However, to potentially affect an increase in the retention of midwives in maternity services in South Africa, the motivating factors and challenges facing these individuals had to be specifically examined. Once these were identified, they may be addressed in order to improve retention of midwives and in so doing enhance maternal and child health care.

1.3 Purpose of the study

The purpose of this study was to explore and describe the work-life challenges and motivating factors that influence the retention of midwives in maternity services in Johannesburg. This was done in order to provide recommendations towards the possible resolution of these workplace challenges to Midwives Obstetric Unit (MOU) managers, facility managers and the district health teams. This information may be useful at a later stage for the development of interventions to improve retention strategies.

1.4 Significance of the study

MOU managers need to focus on workplace challenges for midwives who stay in maternity services. The managers also need to find ways of improving the morale of the midwives at the MOU. Adequate numbers of satisfied, positive midwives should lead to improved quality of maternity care. Thus, findings from this research have implications for MOU managers and the district health system.

1.5 Research question

What challenges and motivating factors influence the retention of midwives in MOUs?

1.6 Research objectives

In order to reach the purpose of the study the following objectives were set:

1 To measure the quality of work-life of midwives in public MOUs.
2 To explore motivating factors and challenges midwives face in public MOUs.
3 To integrate findings related to factors influencing retention of midwives in maternity services.

1.7 Conclusion

In chapter one, the introduction and background to the study were discussed. Accompanying this, the problem statement and significance of the study was explained. Lastly, the purposes of the research and related question, as well as the research objectives were identified. The next chapter entails the literature review of the study.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

In this chapter, a formal scoping review was used. The scoping review was undertaken with the objective to map out and narrate the range of evidence in literature related to challenges and motivating factors influencing retention of midwives. Identification of the evidence included in the review followed a structured process guided by the JBI scoping review protocol described by Peters, Godfrey, McInerney, Khalil, Parker, and Soares (2015). The purpose, method and findings from this review will be discussed.

2.2 Scoping review purpose

The purpose of conducting a scoping review was to review research literature related to challenges and motivating factors influencing retention of midwives.

2.3 Scoping review method

The method of conducting a scoping review was used, following the JBI scoping review protocol (Peters et al., 2015). The inclusion criteria for the scoping review were based by population, concept and context. Many of the studies reviewed consisted of mixed groups of health care professions as the population and often times collectively grouped nurses and midwives as participants. Thus, the population searched were to include nurses and midwives. The concept was retention and work-life aspects, while the context related to working environments in a public sector. The use of a PRISMA flow diagram (Figure 2.1) and a data extraction template (Annexure 1) was used to summarise and collate findings. Three research databases were selected for the purpose of the review, which included CINAHL (Plus with Full Text and Complete), ProQuest and Scopus (Table 2.1). These three databases were decided upon during consultation with the research supervisor.

The search was limited to a Boolean search that included the words “retention”, “midwives”, “challenges” and “motivating factors”. The initial search was limited to only the English language, full text and peer-reviewed sources. The search was categorised into: a) a total number of sources for the search on the Boolean search, b) a number of sources in the last 10 years (2008 – 2018), and c) a number of

sources in the last five years (2013 – 2018). To ensure outdated research was not included sources from the last 10 years (2008 – 2018) were included (n=248).

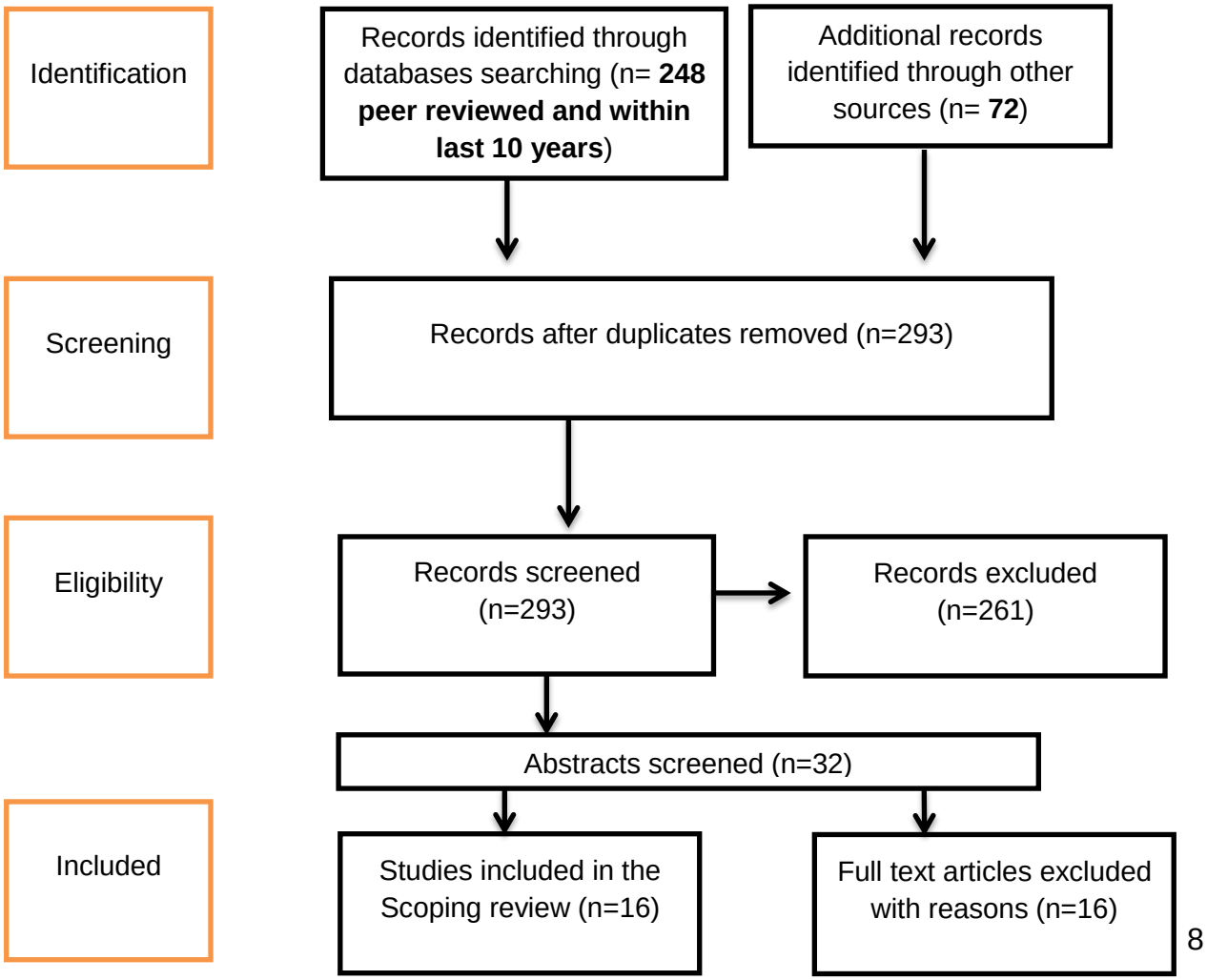
Additional records obtained through various other sources during the development of the research proposal were added from where they were stored on Mendeley (n=72). Sources were scanned for duplications in an Excel spreadsheet by sorting the cells with conditional formatting of cells. The date of access to these articles was on 25 September 2018. A total of 21 duplicates were counted and removed from CINAHL (Plus with Full Text and Complete), ProQuest and Scopus. A further six duplicates were removed from additional sources identified in previous searches that were stored on Mendeley.

The articles were then screened for applicability and appropriateness of the title, of which 72 were identified. Disputed articles were discussed with the research supervisor as a second reader and selected to be included or excluded according to the criteria. Inclusion criteria also entailed that these articles were to include midwives as participants in the studies. Further screening of the article abstracts identified 31 studies to be applicable and appropriate. The full texts of these remaining articles were screened and one relevant referenced study from these articles was included. The total number of articles chosen to conduct the scoping review was 16. The first research objective to explore the motivating factors and challenges that influence the retention of midwives identified in the literature was kept in constant consideration when selecting the final articles to be used for the scoping review. Annexure 1 – Data extraction template provides a trail audit of what was highlighted from the 16 study articles and reasons why the remaining 16 articles were excluded. The findings of the scoping review are described below and were integrated into the discussion of the qualitative and quantitative data analysis.

Table 2.1: Database sources

Database/ Area (Year frame): Nr of years	CINAHL plus with full text	CINAHL – Peer reviewed	ProQuest	ProQuest – Peer reviewed	Scopus	Scopus – Peer reviewed	Total – Peer reviewed
Global (total)	1	1	300	287	52	52	340
Global (2008 – 2018): 10 years		**1**		**198**		**49**	**248**
Global (2013 – 2018): 5 years		1		123		34	158
Africa (total)		1		37		17	55
Africa (2008 – 2018): 10 years		1		37		16	54
Africa (2013 – 2018): 5 years		1		30		16	47
South Africa (total)		0		1		7	8
South Africa (2008 – 2018): 10 years		0		1		7	8
South Africa (2013 – 2018): 5 years		0		1		7	8

Figure 2.1: PRISMA flow diagram



2.4 Scoping review findings

The following aspects were noted during the scoping review:

The geographical locations of the studies reviewed were varied and included areas in Africa, Australia, Asia, Canada, Europe and the Middle East. The theoretical conceptual framework for most of the study articles was related to the retention of staff and the associated individual and/or workplace factors that influence the rate thereof. The methodologies adopted by the studies reviewed were both qualitative and quantitative in nature. Data capturing techniques included the use of survey questionnaires based on various measurements, in-depth interviews and focus group discussions.

Analysis of the results and key findings revealed similarities relating to motivating factors and challenges that influence the retention of midwives. A few aspects overlapped between being a motivating factor, as well as a challenge. For example, midwives were motivated by the opportunity to study further and advance their training, however this aspect was also seen as a challenge as there was a lack of learning and development opportunities (Adegoke, Atiyaye, Abubakar, Auta & Aboda, 2015; Bonenberger, Aikins, Akweongo & Wyss, 2014; Ith, Dawson & Homer, 2012; Pugh, Twigg & Rai, 2013; Wurie, Samai & Witter, 2016). Motivating factors and challenges influencing midwives to continue practising in the midwifery profession were grouped into either “individual reasons”, “relationships” or “workplace aspects”. These findings were grouped as a result of inductive analysis.

Individual reasons: Midwives in the studies reviewed conveyed being motivated by individual reasons that included having professional pride, feeling privileged to attend births and overall job satisfaction (Sullivan et al., 2011). Other individual reasons that motivated midwives were being effective in their roles (Wurie et al., 2016), fulfilling a sense of community service and commitment, as well as being able to make a difference (Versaevel, 2011). Receiving recognition and respect from the community, colleagues and management were also indicated to motivate midwives to stay (Bonenberger et al., 2014; Ith et al., 2012; Mansoor, Hashemy, Gohar, Wood, Ayoubi, & Todd, 2013).

Challenges that may influence the retention of midwives on an individual level included personal family commitments (Pugh et al., 2013) and feeling emotionally taxed by the need to put on a false façade for clients (Holland et al., 2018).

Relationships: Relationships with clients, their families and fellow colleagues (Hildingsson & Fenwick, 2015; Sullivan et al., 2011; Versaevel, 2011) were reported to be motivating factors that kept midwifery participants practising in the profession. It was indicated that making connections with women, their newborns and families was a source of joy, whilst working relationships with colleagues was a source of support. Findings also indicated that mentorship of younger or less experienced midwives was beneficial as these types of relationships provided an additional source of support (Adegoke et al., 2015; Hildingsson & Fenwick, 2015).

Conversely, relationships with the community were experienced negatively as midwives reported to feel constantly "policed" by the community (Wurie et al., 2016). Relationships with other professions of the health care team also posed a challenge. Midwives indicated that these relationships were a source of stress at times and were not always trusting or respectful (Crowther, Deery, Daellenbach, Davies, Gilkison, Kensington, & Rankin, 2018; Versaevel, 2011).

Workplace aspects: As mentioned above, midwives were motivated by the prospect of training and development opportunities provided by their workplaces (Adegoke et al., 2015; Wurie et al., 2016), as well as possibilities of career progression (Adegoke et al., 2015; Bonenberger et al., 2014). Participants conveyed that they were motivated by improved working conditions (Wurie et al., 2016). More specifically, midwives were also driven by being able to work in conditions that enabled autonomous practice (Hildingsson & Fenwick, 2015; Versaevel, 2011), the provision of financial incentives (Wurie et al., 2016) and management that provided supportive supervision (Ith et al., 2012).

However, the majority of challenges that midwives faced were related to their workplaces. The most reported challenge noted was inadequate midwife-to-patient ratios, which was also seen as inadequate staffing or staff shortages (Curtis et al., 2006; Hildingsson & Fenwick, 2015; Holland et al., 2018; Pugh et al., 2013). These

staff shortages may lead to other challenges that burden midwives and influence their intentions to leave the profession. These included midwives experiencing a high workload (Holland et al., 2018; Pugh et al., 2013) and eventual work-related burnout (Creedy, Sidebotham, Gamble, Pallant & Fenwick, 2017). The fear of possible litigation was also found to be a challenge in the workplace (Hood, Fenwick & Butt, 2010) and amplified strain on an already existing problem of increased administrative work (Holland et al., 2018; Ith et al., 2012).

A workplace aspect that was mentioned in five study articles as a challenge for midwives was a lack of financial incentives and benefits provided (Bonenberger et al., 2014; Mansoor et al., 2013; Pugh et al., 2013; Sullivan et al., 2011; Wurie et al., 2016). This included inadequate salaries and a lack of funding for further education. However, non-monetary related issues such as being a part of decision-making processes and a lack of team debriefing were also concerns noted (Holland et al., 2018; Ith et al., 2012).

Working conditions, in general, were reported challenging (Holland et al., 2018; Pugh et al., 2013; Wurie et al., 2016;). More specifically, midwives demonstrated frustration from insufficient medical supplies and a lack of well-maintained equipment (Adegoke et al., 2015; Bonenberger et al., 2014; Ith et al., 2012). Work settings that hindered them from practising autonomously was also a concern as it potentially influenced the retention of midwives (Creedy et al., 2017; Pugh et al., 2013). Furthermore, they reported experiencing a negative workplace culture whereby they were not valued or recognised for their input towards maternal care and experienced a lack of support from administrators and managers (Pugh et al., 2013). Inadequate support and supervision from management were often indicated as a challenge for midwives, with the potential to influence retention of midwives (Curtis et al., 2006; Hood et al., 2010; Wurie et al., 2016).

A lack of permanent position offers and job security were perceived as a challenge by midwives who worked on a contractual or temporary basis (Holland et al., 2018), whilst a lack of career advancement opportunities was noted as a challenge by more midwives who worked on a permanent basis. In general, it was noted that younger midwives valued the opportunity to progress in their careers and as such this was

implied to influence the retention of these midwives (Adegoke et al., 2015; Takase, Teraoka, & Yabase, 2016; Wurie et al., 2016).

From all of the study articles included in the review, the implications for practice and future research included the development of strategies to improve training, development and mentorship opportunities, addressing work-related relationships, as well as recommendations to enhance job satisfaction and employee well-being.

2.5 Conclusion

Chapter two discussed the purpose and method used for the scoping review. Findings provided from the literature provided a background to the research study. It was noted that motivating factors and challenges influencing the retention of midwives could be related to “individual reasons”, “relationships” or “workplace aspects” The next chapter will describe aspects related to research methodology used in the study.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

In this chapter, the research design used for the purpose of the study is discussed. The research setting, population and sampling process is explained, whilst the data collection and analysis processes followed are described. An explanation of integrating data findings is provided, followed by a description of how trustworthiness, reliability, validity and ethical considerations were ensured.

3.2 Study design

A concurrent mixed method research design was used for the purpose of this study. This involved the concurrent collection and analysis of qualitative and quantitative data. This method allowed the researcher to use the strengths of both qualitative and quantitative research in an attempt to confirm and substantiate findings within a single study (Grove, Burns & Gray, 2013). The mixed method notation of QUAL+quan was used in this study as greater emphasis was placed on qualitative data, whilst a lesser priority was placed on the quantitative data. The plus sign (+) indicated that the two sets of data were merged and collected concurrently (Cresswell, 2014).

The study was conducted in two phases that occurred concurrently. The first phase of the study addressed the first objective of the study: To measure the quality of work-life of midwives in public MOUs. The second phase of the study addressed the second objective of the study: To explore motivating factors and challenges midwives face in public MOUs.

3.3 Research setting

MOUs in the Johannesburg Metro District were chosen as the setting in which to conduct the study. MOUs are primary health care facilities in the public sector that render maternity care services to respective surrounding communities. In the MOUs midwives work independently and with very little assistance from other professions of the health care team (for instance doctors). Midwives working in MOUs specifically care for women with low-risk pregnancies during the antenatal, intrapartum and postnatal periods. The antenatal department of the MOUs provide maternity care from seven o'clock in the morning until four o'clock in the afternoons, during week

days and excluding public holidays. The combined labour and postnatal departments provide care 24 hours a day, seven days a week. Women who are identified with high-risk pregnancies (for instance hypertension in pregnancy and twins) are referred or transferred to nearby district or tertiary health care institutions.

3.4 Population and sample

The study population consisted of 165 midwives working in 11 MOUs. Five MOUs in the Johannesburg Metro District were chosen for the study. These MOU sites were conveniently selected as they were geographically accessible, but diverse in their settings. Inclusion criteria for one selection of participants were that midwives were to be registered with the South African Nursing Council, be permanently employed in a midwifery setting position and were able to speak English. There were no exclusion factors prohibiting any midwives from participating in the study. Midwives in MOUs rotate to all midwifery disciplines, such as antenatal clinics (ANC) and labour wards that are combined with postnatal units. Therefore, midwives in all midwifery disciplines were invited to participate.

The first quantitative phase of the study used non-probability self-selection sampling. The main reason for this was because the researcher did not approach all respondents directly, but rather relied on their voluntary participation. The number of participants was a total sample (n = 85) of midwives working in the five MOUs was used. On average there were 17 midwives working in each MOU.

The qualitative phase, which was conducted concurrently with phase one, used convenience sampling of all midwives who volunteered to participate in in-depth interviews. For qualitative data collection Creswell (2017) recommends a minimum sample size of 20 – 30 individuals in order to reach saturation of data, thus a minimum of five midwives per MOU (25 participants) were intended for the study.

3.5 Data collection

The collection of data was conducted in two phases that occurred concurrently. Phase one collected quantitative data, whilst phase two collected qualitative data.

Phase one: Quantitative data

Upon arrival at the MOUs, brief introductory meetings were held with each of the Community Health Centre (CHC) facility managers and MOU unit managers, which were arranged beforehand. Midwives who were on duty at the time were formally greeted and provided with an explanation of the intention of the study, as well as an invitation to participate in the study. Participant information sheets (Annexure 2) were provided for the midwives, who placed these information sheets on notice boards and areas for midwives of other shifts to see. Each MOU was provided with a folder that contained individually enveloped self-administered questionnaires and participant information sheets for each potential participant. Each folder containing the enveloped questionnaires was placed in a visible area for all midwives to see. A sealed box with a deposit slit and clear instructions were left with each folder for all potential participants to complete in their own time. Midwives were informed that the boxes were to be collected in two week's times. Within those two weeks, the researcher went back to each MOU to ensure midwives working other shifts were informed and invited to participate in the study. The MOU unit managers were kindly requested to inform midwives who were working night duty shifts of the study. A total of 85 self-administered questionnaires were handed out to the five MOUs. Each self-administered questionnaire was numbered to reflect the MOU from which data were collected. To ensure anonymity, the questionnaires did not have any personal identifying markers and were put in sealed boxes with other completed questionnaires. These boxes were only opened upon completion of data collection after two weeks. All questionnaires were analysed together.

The self-administered questionnaire was based on Brooks' Quality of Nursing Worklife Survey (BQNW) (Brooks & Anderson, 2005) (Annexure 3). Quality of work-life has been described as "the degree to which RNs are able to satisfy important personal needs through work experiences, while simultaneously achieving the organisation's goals" (Brooks & Anderson, 2005:324). The BQNW is a Likert scale that consists of 42 items and has four sub-scales, namely: "Work-life/Home-life"; "Work Design"; "Work Context"; and "Work World". Each sub-scale represents a dimension related to work-life. "Work-life/Home-Life" addressed the line between experiences at the workplace and at home. "Work Design" related to the content of work and the work that is essentially done. "Work Context" addressed the work

setting and described how the work environment influences the nurse, as well as patient systems. “Work World” related to how general society effects and changed nursing practice (Brooks & Anderson, 2005).

Permission was requested from the BQNW originator author to make changes to the questionnaire. However, this was declined. As a result item descriptions of the questionnaire refer to nurses instead of midwives. Therefore participants were provided with an instructional letter informing them that the following aspects were to be kept in mind when completing the questionnaire:

- Ward clerks, cleaners, kitchen staff and security personnel may be referred to as “unlicensed support personnel”.
- The unit manager may be referred to as “nurse manager/supervisor”.
- Midwives Obstetric Unit may be referred to as “hospital“.
- A midwife may be referred to as “nurse”.
- Any context where the word “nursing” is used may be referred to as “midwifery”.
- If a statement was not applicable to their workplace, participates were to indicate how much they agreed or disagreed if it were available in their current workplace.

Phase two: Qualitative data

On the first day of meeting the midwives, appointments for in-depth interviews were made with those interested in participating in the study. The researcher went back to each of the MOUs on different days to invite midwives from other shifts. The in-depth interviews were conducted at the MOUs, at a time that was most convenient for the participants. It was not expected of the participants to complete the questionnaires in phase one in order to be a participant in phase two. Before conducting the in-depth interviews, the researcher reintroduced herself and explained the purpose of the interview. Participants were informed they would remain anonymous during the interview and informed consent for the interview (Annexure 4), as well as consent for the audio recording thereof (Annexure 5) were obtained. The interviews took place in rooms that were private and lasted an average of 15 minutes. During the interview, the researcher verified responses by repeating back answers the participants

provided, to which the participants agreed or clarified their statement. After the interview, each participant was thanked for their participation. The in-depth interviews with individual midwives were transcribed verbatim. Each transcription was coded with a participant number and no personal identifying markers were made so as to ensure anonymity and confidentiality. These were recorded directly onto the template used for the transcriptions.

These interviews consisted of six questions related to their midwifery experiences (Annexure 6). The six interview questions were based on literature findings during the development of the proposal. Literature and rationale relating to each question are described below:

Question one:

- Please tell me what motivates you to stay in the field and practising as a midwife?
    - Work motivation plays a key role in health worker retention and turnover (Bonenberger et al., 2014).

Question two and Question three:

- Please tell me what the workplace challenges you experience are?
- Please describe how you have overcome these workplace challenges?
    - Workplace challenges were shown to impact the retention of midwives (Pugh et al., 2013; Wurie et al., 2016).

Question four:

- Please describe the kind of support you would like to have in your workplace?
    - Studies have indicated that various forms of support have an influence on the retention of midwives. These forms of support include support from management and fellow colleagues (Curtis et al., 2006; Hood et al, 2010; Sullivan et al., 2011).

Question five:

- Please identify the one most definite critical work-related factor that would make you leave midwifery?

- Although personal reasons play a part in the retention of midwives, a vast amount of studies produced literature on the impact that work-related factors have on the retention of staff and their intention to leave (Adegoke et al., 2015; Bonenberger et al., 2014; Mansoor et al., 2013; Pugh et al., 2013; Sullivan et al., 2011; Wurie et al., 2016)

Question six:

- Is there anything else you would like to tell me?
  - This question was asked to provide participants with the opportunity to elaborate or share any other information.

All midwives who volunteered to participate in the in-depth interviews were provided with the opportunity to answer the questions. A total of 30 participants volunteered and were interviewed. All these interviews were conducted in the span of two weeks; data analysis took place after all volunteered participants were interviewed. During data analysis of the interview transcripts, it was noted that the saturation of data was reached by the 24th participant.

3.6 Data analysis

The study used a concurrent mixed method design that entailed the analysis of both quantitative and qualitative data concurrently.

Qualitative data analysis

Data from transcribed interviews were analysed using thematic analysis. This method was used for “identifying, analysing and reporting patterns (themes) within data” and reporting realities experienced by participants (Braun & Clarke, 2006: 79). An inductive approach was followed as the themes emerged from the data, as opposed to using a set of pre-existing perimeters against which data were analysed, in other words deductive (Braun & Clarke, 2006).

Analysis of the transcriptions was done following Creswell’s (2014) six steps to analysing qualitative data. In the first step, the researcher organised and prepared the transcribed interviews. The second step involved reading and reflecting on the

data gathered to gain a general sense of what was meant. Rough notes of ideas were generated at this stage to refer to at a later stage. The third step was a detailed coding process that included segmenting the information into labelled categories. Annexure 7 provides an example of the coding process used to segment information from one of the transcriptions. The fourth step continued to utilise the coding process and created a description of the setting, themes and sub-themes for analysis. This included allocating a code for each participant (for example Participant 1, Participant 2). In the fifth step, the method of how to represent themes, sub-themes and their descriptions was decided upon. A narrative discussion was chosen to express the data. The final step was the interpretation of the data analysed, which involved individual insights created from the data and a comparison to other studies. The last step included an overview of findings from the qualitative data analysis, as well as a comparison to findings of the quantitative data analysis and scoping review. The integration and interpretation of these findings are discussed later.

Quantitative data

The BQNW that was used for the self-administered questionnaire was originally designed to yield inferential and descriptive statistics. Inferential statistics were not measured as the sample size was small. Descriptive statistics were used to analyse the data collected and were calculated with measures of frequency and central tendency. A total of 62 self-administered questionnaires were received back, which indicated a 73% response rate. From the responses, 58 questionnaires were analysed as the remaining four had information omitted from them.

Each item of the BQNW makes use of a six-point Likert scale varying from “completely disagree”, counting one point, to “completely agree” counting six points. Item number 20 is reverse coded in the scale as it is a negative statement, namely: “Rotating schedules negatively affect my life”. This was taken into consideration when statistics were calculated, done by reversing scores during data capturing. To explain, six was captured to one, five to two, three to four, and vice versa in all instances for item number 20. The total score ranged from 42 to 252 points. A higher total score indicated better quality of work-life (Sirin & Sokmen, 2015). Quantitative data from the questionnaires were captured and analysed in an Excel spreadsheet.

Interpreting the outcomes of both

Findings from both qualitative and quantitative data analysis were integrated into a mixed method report using the Conceptual Framework for Predicting Nurse Retention (CFPNR) by Sawatzky and Enns (2012) (Figure 3.1) . Additionally, findings from the scoping review were incorporated into the framework to triangulate data. The CFPNR consists of influencing and intermediary factors that may influence one's intention to leave their job or current work position. Findings from the scoping review, qualitative and quantitative data were discussed under these influencing and intermediary factors of the CFPNR. Final findings related to the CFPNR were used to provide recommendations for workplace challenges to CHC facility managers, MOU managers and the district health teams.

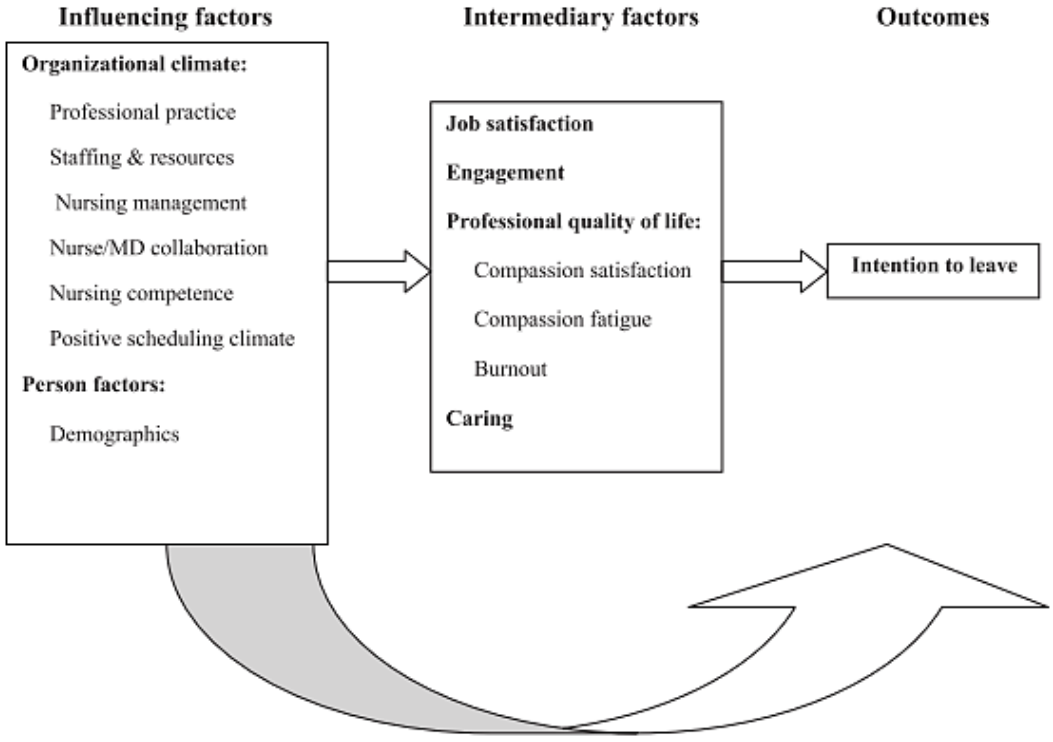


Figure 3.1: Conceptual Framework for Predicting Nurse Retention (CFPNR)

3.7 Trustworthiness and authenticity of qualitative data

The study includes qualitative data, thus internal validity focuses on credibility and authenticity, whilst external validity addresses the "transferability" of the study. (Brink, Van der Walt & Van Rensburg, 2012). Brink et al. (2012) described authenticity (rigour) for qualitative designs as being open, relevant, having epistemological and methodological congruence, thoroughness of the data collection and proper data

analysis. Polit and Beck (2010:493) further explained that authenticity is “the extent to which researchers fairly and faithfully show a range of different realities”. Authenticity was ensured by fully describing the data collection and analysis processes, whilst different realities were discussed. The quality evaluation of the qualitative data obtained during the study was ensured by using Lincoln and Guba’s (1985) method. This method included ensuring credibility, confirmability, dependability and transferability. Credibility was incorporated by ensuring adequate and equal time was spent with each participant, whilst the same questions were asked during each interview. Credibility was also ensured by member checking with participants during the interviews. This was done by repeating responses back to participants and verifying what was said during the interviews. Confirmability of the study was ensured by a supervisor who analysed and coded through the data independently. Credibility was also ensured with an audit trail, which included a detailed description of all steps followed during the study. Dependability was described as determining whether the findings remain constant or may occur in other studies. This was ensured by implementing the code-recode procedure during analysis of the data and compared with findings from the scoping review. After completion of data collection and thorough description thereof, it was noted that transferability may be applied in similar maternity setting contexts.

3.8 Validity and reliability of quantitative data

During this study, validity was concerned with the truthfulness and accuracy of the research findings. It addressed internal and external validity. Reliability refers to the stability, consistency and the repeatability of findings, as well as to the researcher’s ability to consistently obtain the information accurately (Brink et al., 2012). Permission was granted to use the Brooks’ Quality of Nursing Worklife Survey (BQNW) as the self-administered questionnaire (Annexure 8). This was done under the provision that a reliability analysis was to be done and summary findings forwarded to the originator of the BQNW. These conditions were met as discussed below.

The self-administered questionnaire based on the BQNW had test-retest reliability of 0.90 in a previous study conducted in an acute care setting (Brooks and Anderson, 2004). For this study, a reliability analysis was done by means of measuring the

internal consistency of the BQNW sub-scales and related questionnaire items. This was done by the researcher. Internal consistency is a measure based on the correlations between different items of the same tool and determines whether several items that intend to measure the same general construct produce similar scores (Polit & Beck, 2010).

To measure the internal consistency Cronbach's alpha was calculated with the use of an Excel spreadsheet. According to Polit and Beck (2010), a higher reliability coefficient indicated a more accurate measurement of internal consistency, with normal ranges of 0 to 1.00. Cronbach's alpha was measured for each of the sub-scales of the self-administered questionnaire. The alpha coefficient was calculated by first determining the mean square error (MS error) and mean square rows (MS rows) of the items of each sub-scale using Anova: Two factor without replication. Once these were calculated Cronbach's alpha was calculated by using the following formulae: 1-(MS error / MS rows). The alpha coefficient for each sub-scale was as follows: sub-scale one, Work-life – Home-life: 0.25, sub-scale two, Work Design: 0.58, sub-scale three, Work Context: 0.87, and sub-scale four, Work World: 0.32. As the alpha coefficient for sub-scale one and four are below 0.5, the internal consistency was considered unacceptable, whilst the alpha coefficient of sub-scale two measured between 0.5 and 0.6, which was poor. However, the alpha coefficient for sub-scale three measured above 0.8, which indicated good internal consistency for items measuring Work Context.

The alpha coefficient of all the items of the 58 questionnaires used during data analysis was measured to be 0.83, thus indicating that all the items together have a relatively high internal consistency. Experienced midwives were consulted to determine the content validity of the questionnaire (Annexure 3) and interview guide (Annexure 6). Both tools were deemed acceptable and contextualised to the South African context. The questionnaire could not be altered as per instruction from the original author. Therefore the participants were provided with an instructional letter informing them of aspects to be kept in mind when completing the questionnaire. For example, any context where the word "nursing" was used may be referred to as "midwifery".

3.9 Ethical considerations

The following ethical considerations were implemented:

Informed consent was ensured as a participant's information sheet (Annexure 2) was provided and accompanied by two informed consent forms. One consent form was for participation in the in-depth-interviews (Annexure 4) and a second requested permission for audio recordings thereof (Annexure 5). Participants were informed that completion and handing in of the questionnaire was considered as permission granted. Acknowledgement of voluntary participation was incorporated in the information sheet, as well as confirmation of anonymity, confidentiality and the right to refuse participation or withdraw from the study.

Anonymity was ensured by allocating a code instead of a name to each participant interviewed during the study and no personal identifying indicators were marked on the questionnaires or transcriptions. Confidentiality and privacy were assured as to prevent perceptions of intimidations, should they have not wanted to participate. Interviews were conducted in private rooms so as to prevent interruptions and ensure privacy. Beneficence was ensured as the midwives identified as potential participants did not have any harm done to them and were autonomous in their participation, thus safeguarding non-maleficence. Justice relates to the fairness applied to the selection of participants to participate in the study (Brink et al., 2012). This was ensured by allowing all midwives an equal opportunity to participate. There were no unfair advantages to midwives who were selected to participate in the study compared to those who were not selected. The selection of the participants on both day and night shifts was done in two phases. In phase one non-probability self-selection sampling was used, whilst phase two used convenience sampling of all midwives. Appointments were set up with participants at times that suited their schedules.

Approval was obtained by the Postgraduate Assessors Committee (Annexure 9), as well as the Ethics Committee of the University of Witwatersrand for Human Research (Annexure 10). Permission was granted by the Johannesburg Health District (Annexure 11), as well as Facility Managers of the selected MOUs (Annexure 12).

Data management was done according to legal, ethical and statutory requirements. No personal identifying markers linking back to the participants were on the

questionnaires or transcribed interviews. The questionnaires were put in a confidential and sealed box with other questionnaires after completion by each midwife. As data analysis was completed, the originally coded questionnaires were stored securely and scanned electronically in a password protected folder. This will be shredded two years after the publication of the final report or publication of an article. At the end of the study, all research data was copied onto a flash drive and stored at the Department of Nursing for a minimum of six years.

3.10 Conclusion

This study used a concurrent mixed method design with the mixed method notation of QUAL+quan. The study was conducted in two phases that occurred concurrently. Phase one addressed the first objective of the study, whilst the second objective of the study was met by phase two. This study was conducted at five MOUs in the public sector where midwives work independently at primary health care level. All the midwives at the five MOUs (85 midwives in total) were invited to participate in completing the questionnaire and thus non-probability self-selection sampling was used for phase one. In phase two, participants for in-depth interviews were conveniently sampled. Overall, 30 interviews were conducted, transcribed verbatim and thematically analysed using Creswell's six steps to analyse qualitative data (Creswell, 2014). A total of 58 questionnaires, adapted from the BQNW were calculated to yield descriptive statistics of the data.

Ensuring the trustworthiness and credibility of the qualitative data was described in this chapter. Validity and reliability of the quantitative data were ensured by calculating Cronbach's alpha to measure internal consistency. Content validity was verified by experienced midwives. The study fulfilled all ethical requirements and was approved by the Ethics Committee of the University of the Witwatersrand for Human Research. Permission to conduct the study at the MOUs from the Johannesburg Health District and permission to use the BQNW was obtained.

The next chapter discusses qualitative findings according to the themes, sub-themes and categories identified in the thematic analysis.

CHAPTER FOUR: QUALITATIVE FINDINGS AND DISCUSSION

4.1 Introduction

In this chapter, the researcher described themes, sub-themes and categories identified during qualitative analysis of the transcribed in-depth interviews. Findings from these themes are discussed in this chapter.

4.2 Themes, sub-themes and categories

The themes, sub-themes and categories identified during qualitative data analysis are illustrated in Table 4.1 below:

Table 4.1: Qualitative themes, sub-themes and categories

THEME	SUB-THEME	CATEGORY
Motivation to stay: The reasons midwives have chosen to remain practising in maternity services.	**Intrinsic drive**	• Satisfaction when assisting during the birth of a healthy baby to a mother • Making a difference • Managing complications • Working independently • Self-motivated
	Extrinsic motivation	• Managerial acknowledgement • Advanced training recognition
	Lack of motivation	• Intention to leave • Involuntary placement in midwifery • Awaiting to go on pension
Staff shortages: The perceived situation whereby the demand for qualified midwives exceeds the current supply that is employed.	**Midwives workload**	• Staff shortages and inadequate staff-to-patient ratios • Teamwork • Burnout and absenteeism • Interdepartmental shift and duty allocations • Recruitment of young midwives
	Additional support required	• Nursing support staff • Non-midwifery tasks
	Learning and development	• Staff training and experience

THEME	SUB-THEME	CATEGORY
The inner context: The setting within the institution / organisational environment.	**Managerial support**	• Managerial reports, visits and assistance • Financial implications • Equipment and resources • Policies, protocols and guidelines
	Medico-legal risks	• Fear of litigation related to maternal child complications • Litigation support
	Safety and security	• Safe environment • Infection prevention measures
	Multi-disciplinary team support	• Doctors' assistance • EMS / Ambulance delays • Meetings
	Psycho-social support	• Debriefing, counselling and mentoring • Mentoring and advanced trained midwives
The outer context: The setting outside of the institution / organisational boundaries.	**Community views**	• Conflict with the community
	Patient related issues	• Patient conflict • Unbooked patients and lack of antenatal workup • Attending allocated clinics

Four themes were identified from the analysis of the in-depth interviews. The initial findings were categorised and grouped together to form sub-themes. The four main themes emerged by adopting an inductive approach to analysing the data that were categorised and grouped into sub-themes. The themes that were identified were: motivation to stay; staff shortages; the inner context; and the outer context. The themes of staff shortages and the inner context were closely related, however, there were a vast amount of challenges specifically associated with staff shortages and therefore was themed separately.

4.2.1 Theme one: Motivation to stay

This theme related to reasons (or lack thereof) to remain practising in maternity services and consisted of three sub-themes. The first sub-theme involved reasons to stay practising in maternity services that are personally and internally rewarding; this was seen as the intrinsic drive. Participants reported that they felt satisfaction when

assisting during the birth of a healthy baby to a healthy mother. This was supported by the following quotation:

> *"… you become happy after you delivered a healthy baby and a healthy mom. And that – I feel good that I tried my means of giving the proper care to both of them."* (Participant 1)

Another participant shared that:

> *"I love delivering babies. I love the pregnant woman in labour*." (Participant 5)

Furthermore, participants conveyed feeling satisfied from being able to make a difference. This was supported by the participant quotation:

> *"I wanted to do something where I feel I've made a difference and it's continuous. It is not like I feel that I have gone ten steps backwards"* (Participant 3)

Participants were also motivated by being able to manage complications and work independently as quoted by the following two participants:

> ***"****The thought of just bringing a new life into this earth just makes my day. And that you are able to manage complications related to that and make sure that, at the end of the day, you have a healthy mother and child."* (Participant 25)

> ***"****It is independent in fact because today you get this, tomorrow you get this, so… and maybe it is not like something that is constant, it is only delivering, you learn even the conditions that are happening on pregnant women, you know how to manage them, how to prevent them…"* (Participant 13)

Additionally, a participant also reported that she was driven by self-motivation, as quoted:

"All comes with self-motivation you know, to wake up and I need to go to work, ja." (Participant 8)

The second sub-theme described reasons to stay practising in maternity services that were derived from external sources or reward. Participants expressed that they were motivated by managerial acknowledgement, as noted from the participants' quotations:

"And acknowledge good when good is there, ja. You don't need raise in salaries just acknowledge "oh you have done so well, thank you very much!". Not come when there are problems but come every time and acknowledge, "oh you have worked so hard, thank you, thank you, thank you!", which is very rare where I work at the moment." (Participant 22)

"… I would really appreciate – other than us trying as colleagues trying to kind of like help each other, support each other emotionally – management acknowledging that "we get that this is what is happening." Because they say there is nothing they can do about it." (Participant 23)

"Well, it would be nice to be appreciated. Not necessarily in the form of finance. I think for a person to function better you need to be encouraged. You need to be complemented. It is something that does not happen for most of the time." (Participant 17)

One participant reported that she would be motivated if she were further recognised for her advanced training, as quoted:

"… I think the other thing is that they have stopped – you know when you do something you want to be seen to be, like if you do advance midwifery, for example – we knew that at the Nursing Council you would get a bar that recognised advance midwifery. I think the Nursing Council needs to bring back that bar because it gives you that thing that "wow, I am advanced." (Participant 25)

The third sub-theme described reasons for the lack of motivation to stay. A few participants disclosed that they have the intention to leave, however, were not in the position to do so immediately.

> ***"****Maybe why am I not leaving even now it is because I am no longer in that situation of leaving easy…"…"I quit at another institution due to the very same thing that I am telling you – workload, short staffing..."* (Participant 20)

> *"I've done PHC so I am also just trying to get out …" "Not because you don't want to be in antenatal but just because, I think, there are just way too many challenges, so ja... "I have applied; I have got a position in Saudi Arabia, so I just want to maybe go for like two years, or so."* (Participant 23)

Other participants reported that they had not voluntarily been placed in a midwifery setting and were as a result of allocation from upper management or contract agreements. The following participant quotations relayed this:

> *"Ah, it isn't motivation as such, I don't happen to be allocated and then I worked and worked and I just went with the flow."* (Participant 11)

> *"To be honest, there's nothing motivating for me it is, I just doing it because I have to work for my kids but there is nothing motivating seriously."* (Participant 15)

A few participants also revealed that they were not motivated at work and were waiting to go on pension.

> ***"****For now the motivation is only just there is a few years left for patients. Otherwise, there is nothing else left motivating me."* (Participant 5)

> *"… I am just waiting for my time to go on pension."* (Participant 10)

4.2.2 Theme two: Staff shortages

The majority of interviewed participants mentioned challenges related to staff shortages. This concept was understood as the perceived situation whereby the demand for qualified midwives exceeds the current supply that is employed. The workload of the midwives highlighted factors related to the amount of work to be done in a period of time by these assigned midwives. Staff shortages or inadequate staff-to-patient ratios increased workload and was predominantly reported by participants:

> *"The problem is short staffing and too much workload."* (Participant 1)

> *"Okay, the challenges are, number one, the shortage of staff – that is number one. Because sometimes you have only two of you and you deliver four mothers at the same time so it becomes a problem."* (Participant 9)

Other participants further explained that:

> *"… each midwife must have two, it is like two to one the ratio, but that ratio is not working to us because if you are two sisters and you have six patients it seems it is three to one and if there is a complication, you leave everything and you attend to that patient that is having a complication so the other patients are left by themselves."* (Participant 13)

> *"… I feel outnumbered. Many clients that I have to see as well as many babies that I have to see because staff sometimes you can miss some other things because of too much work, workload in a nutshell."* (Participant 19)

Participants in the study conveyed that the shortage of staff had an impact on the quality of care they rendered and to an extent discouraged a few participants from working in the midwifery field. The following two quotations were noted:

> *"… staffing! That is the greatest concern I have. We work under such pressure that you sometimes lose it, it affects your level of work, it affects your collaboration and working with your colleagues and even management to the*

extent that there are times it does effect the patients themselves because your other staff may not be as cool as we are supposed to be." (Participant 22)

"…the fact that they are short staffed, I think is the most important factor that makes me want to leave it." (Participant 24)

As a result of staff shortages, participants explained that they try to overcome this challenge with teamwork and assistance from midwives in other departments. However, this was not always accomplished and posed as an issue itself. The following participant quotations supported this and stated that:

"For me, I think the support I would like to have is more teamwork." (Participant 3)

"We do request from other departments for someone to come and help but most of the time you don't find because people don't like midwifery." (Participant 4)

Another participant shared that:

"To like solve problems. If one has a problem you can ask the other person. To support as a group or as a whole team. That would make a difference." (Participant 5)

Perceived staff shortages and associated high workload also resulted in participants reporting burnout. Participants indicated that burnout leads to absenteeism which in turn exacerbated the primary challenge of staff shortages. Participants stated that:

"We become overworked. We become overworked and it is not good because now we become impatient and we feel burnt out…" (Participant 28)

"…we are outnumbered but ja, in a nutshell, that is that. Because now, you have the burnout situation which is not good and that will cause absenteeism which is not good." (Participant 19)

Other repercussions of staff shortages were that participants had to move inter-departmentally and experienced dissatisfaction with duty allocations. For example, participants from the ANC were instructed to assist in the labour and postnatal unit for the day when there were insufficient midwives on duty or when a high influx of patients occurred. As a result, this increased the workload for the midwives remaining in the ANC for the day. The following participant stated that:

> *"We sometimes call one – the ANC to come and help, as just to come. Like yesterday I said we only had one midwife. We call the sister in the ANC and she came …"* (Participant 14)

> *"… we must overstretch ourselves and this thing moving around to departments – is a bit strenuous for me."* (Participant 1)

Other participants explained that:

> *"Because sometimes it's the two us and we will be having around 80 patients. Yes, it is a challenge. Because they are always taking people from here and not replacing them."* (Participant 2)

> *"… so this rotating staff, I don't think it is not a good idea especially in speciality departments because you need staff who knows what they are doing."* (Participant 3)

Moreover, a participant disclosed that:

> *"… the type of off-duties. I don't like them. I don't think I will be working here until I go on pension only because of those off-duties, they are more here than at home. You need to have time …"* (Participant 5)

Participants alluded to the recruitment of younger midwives as being the way forward and addressing the shortage of staff. However, this was not always a possible option. One participant asserted that:

"… I have noticed here is that you have like very old midwives and you don't have like young people. I am not saying that young people are important or what not but you need people who have just recently studied and who know the recent guidelines and protocols and what not. Because they (older midwives) *are doing things the old way."* (Participant 3)

Other participants elaborated that:

"…you are working every 12 months basically. So how am I going to be okay emotionally, psychologically? It means I will not be able to even accommodate a student nurse. So that then causes a decline in most of the students being interested in being midwives because there is no one who is instilling that interest or love that they have, that is supposed to be instilling in them so that they can become midwives and that needs to be looked at, definitely." (Participant 17)

***"…** if they can attend to it midwives won't want to leave the maternity because some of the junior nurses don't want to work at the maternity*..." (Participant 10)

The second sub-theme identified under staff shortages was additional support required. This entailed when midwives require assistance from other categories of staff, such as enrolled nurses and administrative personnel. It is within the midwives' scope of practice to provide holistic and comprehensive care to patients and their newborns. However, it was expressed that they required assistance with nursing tasks that were not necessarily to be done exclusively by midwives. These tasks included the monitoring and recording of patient vital signs, as well as the administration of medication under the supervision of midwives. One participant stated that:

"… in this particular institution, it is only midwives that are working in labour ward. They don't have staff nurses… they don't have categories of nurses. So it would be nice for them to have maybe staff nurses that would give

injections, while they do vital signs and bed making and all that. They do everything by themselves!" (Participant 20)

Participants also reported that they were hindered by non-midwifery tasks such as additional administrative responsibilities. A few participants explained that:

"…they require you to submit to them the statistics of daily of monthly and then, you do those things and then once the copies get lost you are supposed to restart again but because of time factor and the demand of patient care that you are to supposed to rendered, it is time wasting …" (Participant 1)

"… then you would have to do your stats, you need to do import your stats and still continue working at the same time. You need to schedule people for training, you need to be on par – you need to know what is happening because you can receive a call anytime. If the facility manager is not around you need to know what is happening in the office and you need to also sort of assist wherever it is needed." (Participant 17)

"… also the clerks. They can also hire more clerks." (Participant 2)

The sub-theme of learning and development was related to the development of midwives capabilities, skills and competencies to remain successful in rendering care in maternity services. Participants reported that they were prevented from further learning and development, as not all participants interested could attend training at the same time due to a shortage of midwives in their workplaces. Participants stated that they were to take turns when applying to study further. The lack of further training opportunities was seen as a challenge by most participants interviewed:

"Staffing in terms of, you know there still needs to be continuous personal development at the end of the day. So you find that, at times, you cannot schedule people for trainings because there will not be staff on that particular day." (Participant 17)

"… that I noticed that staff development, you know, there is not too much because we talk about shortage, we can't go to course because of shortage you know that is one of the constraints that comes in between us, getting to (learn) ..." (Participant 8)

A participant further elaborated that:

"… even if we can apply for study leave – it gets rejected. The main reason being, no, the shortage. One person per institution should go to school. Those are the challenges. There's are not much flexibility of, you know, for us. Even if you do it part-time, they are not taking you to school …" (Participant 8)

As a result of not having the opportunity to study further, a participant reported that they rely on their existing knowledge and experience:

"We are just using the things that we do have and even our experiences." (Participant 13)

However, it was noted that some participants were still provided with the opportunity to attend skill development training sessions, as quoted by the participant:

"Okay, we are taken for trainings, we are normal trained, we do ESMOE training, we do HBP, we do for PMTCT, we go for family planning training. So most of the things that you will be doing, you go for training for." (Participant 17)

4.2.3 Theme three: The inner context

The third theme identified related to the setting within the institution or organisational environment and consisted of five sub-themes. The first of the sub-themes involved support from managers and upper management. This was mentioned by most participants. A few participants conveyed that they were motivated by the support of their managers.

"… our operational manager, the one we have now, she is very supportive so at least, you know, able to get our groove back and work ..." (Participant 8)

***"**I think mostly the support that I get from my supervisor… very supportive and that is what is still keeping me here."* (Participant 4)

However, participants interviewed often indicated they experienced a lack of support from either their managers or upper management. Participants shared that issues raised were often reported to their managers, however, remained unresolved:

"Yes, we refer the issues to the facility co-ordinators. She tries by her all means but sometimes she does not win." (Participant 1)

"We do report to managers. Sometimes she brings someone to help us; sometimes they also have their own shortages down there so there is no other way…" (Participant 2)

"We try to overcome by reporting to our manager's office. There is no help at all. They don't, they don't help at all." (Participant 10)

They suggested that they would feel supported if management were to visit and monitor the MOUs more often. Two participants related the following:

"… the monitoring is not really there from management side." (Participant 4)

"Ai, if management could come, not when there is a problem, when all is well and everybody is happy to support and say, "what did you do? Are you happy? If you are happy, okay" Like you need support sometimes someone to say "well done". That's it. Just somebody to come and say "well done" and then, "are you having any challenges? How do you think we can solve the challenges?" Then we both come up with a plan how can you solve the problems. That would be nice, a support system." (Participant 5)

Another participant shared that:

"To be honest with you since I arrived here I found this thing that the manager does not come this side – I think once. Ja, once so at times we do think we are neglected at labour ward because I think even the matron should not only wait for us to tell her when we have challenges. I think the matron should also come and see and say, 'Hi guys, how are you doing? Any challenges?' So I think we are neglected in that way." (Participant 15)

Participants conveyed their feelings of frustration when referring to support from management:

"… if our managers can listen to us and put themselves in our boots and see how frustrated it can be to work under these conditions that we are working here, then, really things can be better." (Participant 9)

"Well our employer, I think they don't care …" "… they just want results, results, results really. They don't care what they are putting you through, so nothing much is being done." (Participant 21)

A lack of financial incentives and benefits were frustrating and a concern raised by participants. These financial incentives included night duty and speciality allowances. The following participant quotations indicated that:

"… staff members are not getting their night duty allowance, they are not getting all the allowances that we were getting before because of all the litigation that are happening." (Participant 3)

"You go to school, you come back and they tell you that you cannot get paid for a speciality because your setup is not like a – you actually have to be in a labour room." (Participant 5)

"Financially of course, because we also have families, the time is hard for us! The economy is hard for everyone. We are – the rate at which we are paid

versus the amount of work I think, we are not taken care of well enough, that as well." (Participant 27)

A significant challenge mentioned by most participants was the provision of well-maintained equipment and material resources. Participants shared that a lack thereof influenced the care they rendered to women and their newborns:

"Even beds – beds were a problem. We had to nurse pregnant women on the floor like creating floor beds." (Participant 3)

"In terms of material resources you work, there are no gloves, you work there are no cord clamps, you work there is no suturing material – those type of things – it is not motivating – it is deflating to come to work." (Participant 5)

"We run short of basic things. This is midwifery by the way. If I don't have an Anti-D, if I don't have a Foley's catheter, if I don't have things to wear on my hands, that is just below par. It is just below standard and I cannot accept that but we still work …" (Participant 22)

Two participants elaborated that:

"Most of the time we do not have cord clamps. We have to tie with suturing material. We do not know how safe that is! How long is it going to last before it opens and baby bleeds?!" (Participant 6)

"… There is no urine catheter. You just need to put in a catheter, secure it and put a glove and make sure that tie that thing in so that the patient can be helped, just to stabilise the patient for the ambulance to arrive." (Participant 11)

Additionally, a few participants commented that at times there were adequate equipment such as blood pressure measuring machines, however, these were not always well-maintained. A participant's quotation asserted that:

"They are not being calibrated and with the workload on the only 'Dinamap' for each and every patient. They need to be serviced but they are not being serviced …" (Participant 10)

During the in-depth interviews participants also mentioned aspects of policies, protocols and guidelines that were challenging. They claimed guidelines were not always clear or available as supported by the following participants' quotations:

"There is still a problem with midwives as well that are not trained. I don't say they do not know what they are doing. They don't know what is expected of them because even protocols and guidelines change all the time." (Participant 3)

"I think there must be clear guidelines – SOPs. Those things that guide us for them to be able to monitor us because if those things are not in place how are they going to be able to monitor?" (Participant 4)

Furthermore, participants were dissatisfied about not being part of the decision-making processes involved with protocols:

"… even the protocols; there is no consultation when they are being reviewed. Even policies, there is no consultation. If they can come down here on the ground floor for consultation I think we might help each other to meet with other mind …" (Participant 10)

The second sub-theme under theme three – the inner context, referred to factors associated with medico-legal risks. This was a common occurring subject mentioned in nearly all participant interviews and referred to potential hazards that involved both midwifery and legal aspects within the workplace that may cause harm to the patient. The majority of participants claimed that being involved in legal processes was most definitely a critical work-related factor that would make them leave midwifery. The fear of litigation associated with maternal child complications was conveyed by the following participant quotations:

"…I have learned to love the midwifery field. Although I am very scared of going to labour ward …with all the litigations and that is happening" (Participant 4)

"Ai, midwifery ne. Because there is so many complications and because people are coming to book late and they have problems and they blame us. That is my problem. That is why sometimes I think of leaving." (Participant 2)

"For us here we didn't experience a maternal death like that so I think that with a maternal death that has booked, done everything that thing can make me traumatised for the rest of my life and then leave." (Participant 7)

Participants expressed that they would not be adequately supported if faced with litigations, as per the following participants' quotations:

"… something happens, there is an incident and I have tried maybe to get support from my colleagues or even the supervisor and maybe if there is nothing, no support, then I think I would consider leaving." (Participant 4)

"Because usually the employer just cares about how did that happen. Not, how are you feeling? What happened? Like after this – how are you carrying on, you see?" (Participant 6)

"The challenges again will be, you know, we don't get the support from the management. Especially if there is an adverse event you know." (Participant 29)

The third sub-theme identified under the inner context related to safety and security. This was considered as the condition of being free from harm or risk and the protection of individuals from negative outcomes. The individual referred to both the participants and their patients. Participants reported that the environment in which they work was not always safe, as quoted by a participant:

"Ja, because it is not really a very safe environment to work in so … so they gave us a key to try and lock up maternity when we have, every time someone comes, someone knock from the outside, there was a bell but it has been removed now so … it isn't really functioning …" (Participant 23)

The participant further explained that:

"… if you are busy here and someone is at the door outside you have to leave what you are doing and go at night and try and open the back-lock door is really not on and sometimes you do not know who is at the door. By the time you get to the door, if it is someone who you are not supposed to have opened to, you can't turn back at the same time …" (Participant 23)

Another participant also commented on how the environment negatively affected patient outcomes, including their safety and dignity:

"It is cold there. You can think hypothermia to the child after delivery, it is cold, it is uncomfortable. Privacy is not very – it is there but for someone who is delivering it is not there …" (Participant 6)

A lack of resources such as gloves and linen also render the environment unsafe for participants and their patients, as infection prevention measures could not always be maintained. The following participants disclosed that:

"… although it is infection control linen, we don't have – the very same linen that we use, if the patient has slept in it we just turn it over for the next patient to come, ja. That is how we compromise and at times we do our own linen. We wash and it has to be ironed for infection purposes but because of that we just wash it, they put it in the sun and put it back on the beds. We compromise like that." (Participant 8)

"When we have to do the physical exam we don't really use the gloves but if we should check the areas where we do need the gloves we would use one glove." (Participant 4)

Another participant explained:

> *"… one of the saving mothers causes of maternal and neonatal death is sepsis but if you look at the mattresses we use, when it comes to sterility it is very bad …"* (Participant 17)

The inner context also consisted of a sub-theme related to multi-disciplinary team support. This was associated with the required assistance from members of the health care group who are from other professional disciplines. These other professionals referred to by the participants were doctors and emergency medical services (EMS) personnel. Participants indicated that when caring for patients with medical complications or patients who were identified as high-risk patients they seek support from doctors. However, they reported that this support was not always readily available, as claimed by the following participants:

> *"Ja, even just to get a paediatrician – it becomes a problem at (*hospital name) because you keep on phoning and phoning and they will tell you that the on call doctor is busy somewhere hence you get stuck with babies that are supposed to be transferred …"* (Participant 1)

> *"… and we don't have a backup, even in the doctors, you can't – you go to general site and ask a doctor – you have a problem – he will tell you I don't have any obstetrics."* (Participant 13)

Another participant asserted that:

> *"We have to transfer patients out, it takes long. You have to get a doctor. Sometimes the doctor is busy in theatre or somewhere …"* (Participant 22)

Additionally, when patients were to be transferred to higher levels of care, participants were hindered by delayed transportation from EMS. Participants conveyed their frustration with the following quotations:

"… if you have an emergency, you need an ambulance. You will wait until your patient will deliver no matter how urgent is the case. So it is really frustrating because we end up having more problems because of the EMS. They don't respond as quickly as possible … Eventually, the ambulance will come after a long time." (Participant 9)

"… another challenge would be the ambulance. We wait for the ambulance for five hours, eight hours." (Participant 16)

One of the participants explained further that:

"You know, in fact, you call in time, you have resuscitated, your baby is fine but then the waiting, you know, the baby needs to be next to the doctors, the mother's BP is high or the mother is bleeding post-delivery. You need an ambulance like now." (Participant 16)

Furthermore, the participant stated that:

"We had a baby that was delivered round about five past eleven. The ambulance only came at quarter past four." (Participant 16)

One of the participants expressed that delayed transportation was a major concern for her and would result in her intention to leave, as stated:

"If I can have mother died in front of me while I am still waiting for an ambulance – that really would make me want to quit." (Participant 9)

Participants mentioned that meetings were conducted on a monthly basis with other members of the health care team in an attempt to address issues, as stated:

"There is not much we can do about it but we do attend referral meetings, like yesterday I did attend. These things are being discussed on, you know, the level where there are doctors, everybody is concerned. The matrons will be there, you know, even the EMS person will be there to represent the EMS

itself. So, it is a bit of a challenge because even them they are facing those challenges you know." (Participant 16)

The fifth sub-theme identified was associated with psycho-social support. This was seen as the assistance provided to midwives in order to reconcile from psychological events and rebuild social structure after critical events. Participants remarked that there were programmes in place to assist with emotional support, as stated by the following participant:

"The wellness programme – at least they provided it – the government has provided that wellness programme for us because we got emotional problems, just to help us emotionally …" (Participant 19)

However, not all participants were aware of this programme or associated support systems, as commented below:

"I wish sometimes you could get counselling. Sometimes you deliver a dead baby. Sometimes… the counselling I think in this hospital facility is very bad. Because you have your own problems…" (Participant 14)

"… at times we have some still births, there is no counselling for the midwives. You feel bad after the incident has happened but I don't remember in my entire practice that midwives have been taken for counselling after that incident has happened" (Participant 10)

Participants have access to a wellness programme that they may contact in their own time. However, they further commented that there was a lack and at times an absence of debriefing, which was demotivating. The following participants stated that:

"They don't do the de-briefing sessions whereby midwives can sit down and talk out their frustrations. I think that would also help just to cheer them up and help them understand what is going on and how to cope in strenuous situations." (Participant 20)

"From time to time we need to be debriefed because you get your still births, you get your macerated still births, you get all these kind of things and there is no way that you can function like a robot. So you need to be taken for debriefing sessions where you are able to vent out your frustrations …" (Participant 25)

Another participant commented on how mentoring would assist her with feeling supported, however, this was no longer practised or implemented:

"You know, before when I joined here there were people who came here to mentor us from the government. At least that boosted our self-esteem. You always felt that at least there is somebody near us whom we can share our problems with." (Participant 27)

4.2.4 Theme four: The outer context

The outer context highlighted the setting outside of the institution or organisational boundaries. Two sub-themes were identified and related to the community and patients who are cared for by midwives. The first sub-theme of community views was the perceived thoughts and actions of the surrounding community by midwives. Participants expressed they were confronted with community family members who brought women with high-risk pregnancies or complications to the MOU labour wards. This was conveyed by a participant who said:

"… there are challenges we have is for families when they bring the patient when you explain to them that patient was supposed to be in hospital, they find that the hospital and clinic is the same why should they run around with the patient. Sometimes that lack of knowledge to our families and we need to come down and explain to them that, no patient we will see and then we will call the ambulance. They usually think that the clinic is the getaway for patient to the hospitals." (Participant 7)

Participants appeared discouraged when commenting on the conflict they experienced from the community, as well as perceived disdain from society and the government. The following participants' quotations were noted:

> *"Because at times you would find that, okay, you have monitored the patient properly according to the nurse. You have done everything you needed to do, but you find that complaints is coming and when you try to assess it you were literally being fair to the patient; it was never your intention but you know how the family and the relatives can make it seem like, you know, that ..."* (Participant 8)

> *"I think the support from the department as a whole because the way I see it the community is that they are always looking for something to use against us and to work knowing that even the government is not on our side really puts a strain on us."* (Participant 15)

A participant further elaborated that:

> *"… they are calling us the devils and what you see. So on national TV so I think it also makes the community not to respect us."* (Participant 15)

Similarly, another participant stated that:

> *"Even our government. Like when they make statements you know. I don't know how they put it there but we are made to appear evil to all the patients, to the community. And you know what the community when they come here, they have that attitude 'you must work'."* (Participant 27)

Participants also shared stories of challenges they encountered with patients. The second sub-theme related to the perceived actions of patients by midwives. One of the participants described a confrontation she had with a particular patient:

"It is very, very difficult and you find such a very, very difficult patient who doesn't want to co-operate when you talk to her. She insults you …" (Participant 14)

The participant further explained that:

"She didn't want to be discharged home. I tried so much. I tried to convince her 'you have to go home, you can't sleep in the hospital for no reason.'" (Participant 14)

"She even urinated on the floor. When we shout at her 'why are you doing this?' (The patient responded) *'Where am I supposed to urinate?'"* (Participant 14)

Another participant relayed her encounter with a patient:

"And with the patient – yesterday we had one – … She comes in, she is not having a card. Where is your card? No, I forgot to bring the card. We say, 'okay, wait for us we are still busy', she goes and lies on the bed and starts pushing …" (Participant 21)

Participants also conveyed their frustration when referring to the challenge of unbooked patients and the lack of an antenatal workup being done. Unbooked patients were seen as patients who come to the MOUs in labour without previously been cared for or monitored during the antenatal period of pregnancy. A participant commented that:

"… patients they aren't booked, they also can be a challenge. We have patients that aren't booked and they just walking in and you find that they are already fully dilated and you don't have a chance to detect the problems that a patient would have that you would have detected if the patient was booked …" (Participant 26)

This was noted with another participant who explained:

> *"… the patients that are not booking, you know, is a challenge because getting a patient that is not booked in the labour ward is quite strenuous because you have to do the ante-natal booking and everything before you can deliver the baby."* (Participant 7)

Furthermore, participants reported they are faced with a challenge when patients came to their specific MOU instead of other health care facilities within their catchment areas:

> *"Our patients, nê, they don't make use of the nearer clinics that are five steps away from their homes, so we are ever full, especially at the clinic and, remember, we are not supposed to chase them away. So we take them, give them the right – proper advise to go to their clinics* (in) *their catchment …"* (Participant 16)

Another participant explained the risk that this challenge posed:

> *"Our patients are so clever nowadays. Even if they know their clinic is not this one, they would rather change their address …"* (Participant 20)

The participant further explained that:

> *"Should anything happen to that patient or probably you have taken some investigations or something, you want to trace, it is difficult to trace that patient because you won't find them at that address."* (Participant 20)

4.3 Discussion

In light of the themes and sub-themes that emerged from the qualitative data, it was noted that the majority of challenges experienced by midwives who partook in the study have been documented in previous literature. All findings from the qualitative data may be aligned to influencing and intermediary factors of the CFPNR by Sawatzky and Enns (2012), which may have an impact on one's intention to leave their job. Under theme one, it was noted that participants were intrinsically and

extrinsically motivated to remain practising. Intrinsic factors related to being able to make a difference and attending births, while extrinsic factors included financial incentives, as well as acknowledgement and recognition by others. Similar findings were present in studies by Ith et al. (2012), Mansoor et al. (2013), Sullivan et al. (2011), Versaevel (2011) and Wurie et al. (2016). Thus, by ensuring midwives are acknowledged and recognised for their work well done, this may influence their choice to remain to practise in the profession.

Under theme two, a shortage of staff was predominantly mentioned as a challenge by all participants. This was a concern as it was frequently identified in previous literature that this factor influenced the retention of midwives (Curtis et al., 2006; Hildingsson & Fenwick, 2015; Holland et al., 2018; Pugh et al., 2013). As a result of staff shortages, participants experienced burnout and indicated that their workload and learning development opportunities were impacted. This may further influence their intention to leave and thus decrease the retention of midwives. The shortage of staff also has consequential negative effects on patient outcomes for women and their newborns (Bremnes et al., 2018). The importance of teamwork was emphasised by participants, whilst literature indicated that positive and supportive relationships with colleagues and the non-midwifery staff were motivating factors for the retention of midwives (Crowther et al., 2018; Sullivan et al., 2011; Versaevel, 2011). By working on team collaboration within midwifery groups, as well as with other professions of the multi-disciplinary team, midwives may feel more encouraged and supported to remain to practice in their units.

Theme three predominantly consisted of participants conveying their challenges related to inadequate supplies and equipment, a lack of managerial support, the fear of litigation and the need for psycho-social support. These findings were consistent with challenges experienced by midwives in other studies and influence their decision to remain practising or intention to leave their jobs (Adegoke et al., 2015; Curtis et al., 2006; Holland et al., 2018; Hood et al., 2010; Wurie et al., 2016).

The qualitative findings suggested that formal structures are to be put into place, that will provide emotional and litigation related support and assistance. This was supported by Hood et al. (2010), who also indicated midwives were not always

mentally or emotionally prepared to face impending litigations. Other suggestions included management were to provide supportive supervision and conduct performance appraisals, as supported by Bonenberger et al. (2014). It was also recommended in the literature that health systems were to provide adequate equipment and supplies in the workplace, as this influenced job satisfaction and inadvertently retention of staff (Adegoke et al., 2015).

The last theme revealed the negative relationship participants experienced within the community, as well as with their patients at times. Similar findings were noted in a study by Wurie et al. (2016), whereby participants experienced strained relationships within their surrounding communities. Hildingsson and Fenwick (2015), Sullivan et al. (2011) and Versaevel (2011) indicated that relationships with clients and their families were motivating factors that kept midwifery participants practising in the profession. Thus, by implementing strategies that could enhance relationships within the community, this may improve work-life for midwives. These strategies may involve the development of effective communication skills, which facilitates trusting relationships, as supported by Crowther et al. (2018).

4.4 Conclusion

This chapter described themes, sub-themes and categories identified through qualitative data analysis. It was noted that participants responded by mentioning more challenges experienced, as opposed to motivating factors to remain practising in the profession. Challenges such as staff shortages, a high workload, a lack of resources and equipment, as well as managerial support were predominantly mentioned by participants. The next chapter will describe and discuss the analysis of the findings of the quantitative data.

CHAPTER FIVE: QUANTITATIVE DATA FINDINGS AND DISCUSSION

5.1 Introduction

The chapter initially describes an analysis of the participants' demographic information. This is followed by a brief summary of participants' scores obtained in the self-administered questionnaires based on the BQNW. Descriptive statistics were calculated by measures of frequency and central tendency. These statistics were discussed according to age groups, questionnaire sub-scales and overall analysis of individual items in the questionnaire.

5.2 Findings and discussion

A total of 85 questionnaires were distributed to the MOUs and of these, 62 were received back, therefore a 73% response rate. Four of the 62 questionnaires were excluded from the analysis as a few items from the scoring Likert scale of the questionnaire were omitted by participants, thus 58 questionnaires were analysed. The questionnaire consisted of two sections, namely section one, which consisted of the BQNW Likert scale, and section two whereby participants filled in demographic data.

The following demographic data of the participants were noted from section two of the questionnaire (Table 5.1): Participants were aged between 25 and 63 years, of which more than half were between the ages of 40 to 59 years (n=36, 62%), whilst 7% (n=4) of the participants were younger than 29 years. More than half of the participants' highest qualification obtained was a diploma in nursing (67%, n=39) that includes a basic midwifery qualification. The demographic item asking whether participants were certified in their speciality area was interpreted as whether they had any form of advanced training, to which 46% (n=27) of participants confirmed they underwent specialised training. Participants further elaborated that the specialised training included advanced midwifery (n=20, 74%), nursing administration, trauma and primary health care. Just over three-quarters of the participants (78%, n=45) rotated shifts between day and night duty, of which 26% (n=15) confirmed to receive additional compensation for rotating shifts.

Table 5.1: Participant demographics

Demographic data description	Number of participants	Percentage
Age group (n=58):		
20-29	4	7%
30-39	11	19%
40-49	17	29%
50-59	19	33%
>60	1	2%
unknown age	6	10%
HIGHEST earned diploma or degree in nursing (n=58):		
Diploma	39	67%
Associate degree	6	10%
Doctoral degree	1	2%
Other	8	14%
Unknown qualification	4	7%
Marital status (n=58):		
Married (First marriage)	24	41%
Married (Not first marriage)	2	3%
Widowed	3	5%
Divorced	5	9%
Separated	1	2%
Never Married	20	35%
Unknown marital status	3	5%
Are you responsible for the care of your (and/or your spouse/partners) elderly parents (n=58)?		
No	21	36%
Yes	31	54%
Unknown	6	10%
Do you rotate shifts (n=58)?		
No	8	14%
Yes	45	77%
Unknown	5	9%
Do you receive additional compensation for rotating shifts (n=58)?		
No	36	62%
Yes	15	26%
Unknown	7	12%
Are certified in your speciality area (n=58)?		
No	26	45%
Yes	27	46%
Unknown	5	9%
Types of specialised training done (n=27):		
Advanced midwifery	20	74%
Other (Admin, Trauma, PHC)	3	11%
Unknown	4	15%

Data from the questionnaires were captured in an Excel spreadsheet and were summarised in Table 5.2. The key to factor analysis-derived subscales (BQNW) in Annexure 8 was used to identify which items were to be analysed per subscale.

Table 5.2: BQNW section one summary

Participant number	Work design	Work-life – Home-life	Work context	Work world	BQNW total score
1	40	22	69	18	149
2	47	30	89	17	183
3	34	28	76	15	153
4	29	29	97	19	174
5	23	25	39	15	102
6	28	27	60	19	134
7	26	21	57	15	119
8	32	25	83	25	165
9	31	22	73	15	141
10	33	25	65	17	140
11	33	26	52	11	122
12	34	27	84	16	161
13	31	29	69	17	146
14	40	27	69	15	151
15	32	15	56	15	118
16	29	28	72	16	145
17	40	32	75	14	161
18	32	10	92	18	152
19	31	27	40	13	111
20	33	29	89	16	167
21	37	34	95	20	186
22	32	27	84	17	160
23	37	25	70	16	148
24	34	30	86	19	169
25	44	34	95	19	192
26	47	23	104	15	189
27	38	24	83	20	165
28	35	25	68	16	144
29	44	23	104	16	187
30	26	18	59	15	118
31	33	28	92	25	178
32	42	28	57	16	143
33	50	26	103	17	196
34	52	28	106	20	206
35	53	31	106	25	215
36	27	20	65	13	125
37	50	29	92	24	195
38	36	34	71	17	158
39	33	22	58	18	131
40	39	23	90	17	169
41	33	19	72	17	141

Participant number	Work design	Work-life – Home-life	Work context	Work world	BQNW total score
42	34	21	71	19	145
43	36	24	87	20	167
44	40	28	94	21	183
45	36	23	85	18	162
46	38	21	82	16	157
47	35	25	76	16	152
48	41	25	74	25	165
49	29	25	62	20	136
50	22	22	56	8	108
51	39	28	82	20	169
52	27	24	78	11	140
53	28	15	54	7	104
54	28	21	55	10	114
55	22	16	50	9	97
56	24	17	56	7	104
57	36	31	75	20	162
58	23	26	57	14	120

The following key below was used to interpret scores of the Likert scales of section one. This key was provided by the author who developed the BQNW.

Table 1.3: BQNW section one score key

Interpreting scores	Range of scale	High	Moderate	Low
Total BQNW Score	42 - 252	183 - 252 = high BQNW	113 - 182 = moderate BQNW	42 - 112 = low BQNW
Work-life – Home-life sub-scale	7 - 42	30 - 42	19 - 29	7 - 18
Work design sub-scale	10 - 60	45 - 60	27 - 44	10 - 26
Work context sub-scale	20 - 120	78 - 120	39 - 77	20 - 38
Work world sub-scale	5 - 30	21 - 30	13 - 20	5 - 12

Data analysis of section one of the BQNW Likert scale revealed the following findings relating to quality of work-life:

On average, all age groups obtained moderate scores for their overall quality of work-life (Figure 5.1). Each age group also displayed moderate scores in the sub-scales of Work design (Figure 5.2), Work world (Figure 5.3) and Work-life – Home-life

balance (Figure 5.4). It was noted that the Work context sub-scale displayed higher scores in the age group of 50 – 59 years and participants who did not specify their age. This was highlighted in red. Moderate scores were noted for the remainder of the age groups (Figure 5.5). This sub-scale addressed the work setting and describes how the work environment influenced the midwife, as well as patient systems. Therefore, the midwives of the age group 50 – 59 years' experienced their work setting more favourably as opposed to other age groups.

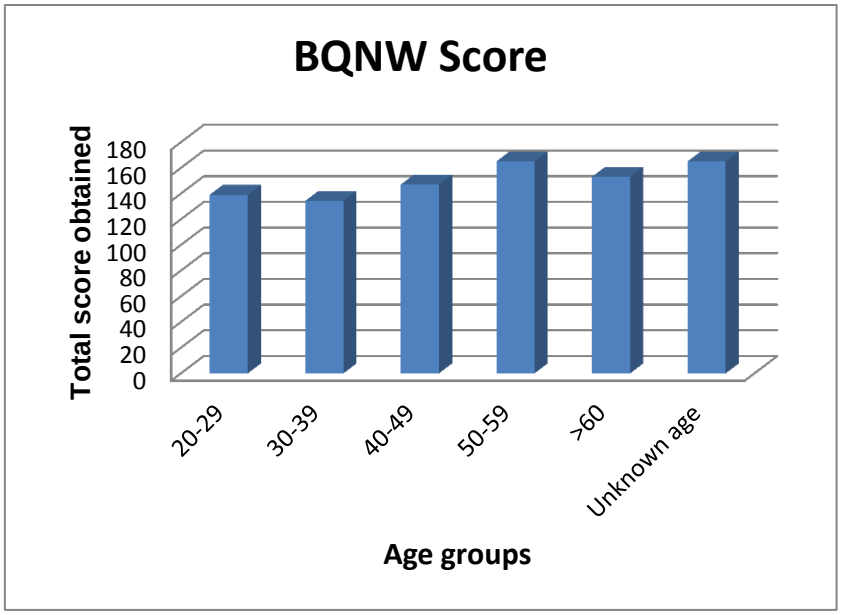


Figure 5.1: BQNW by age groups (n=58)

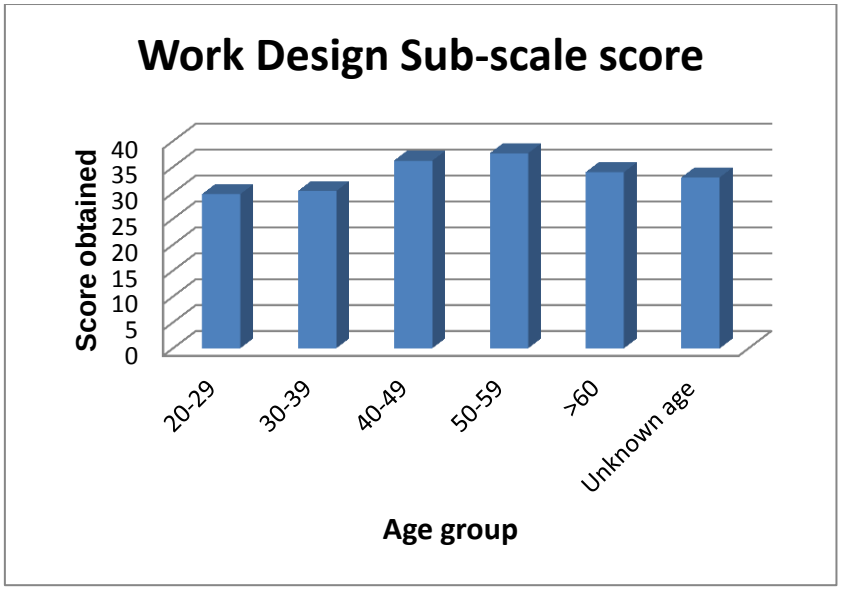


Figure 5.2: Work design by age group (n=58)

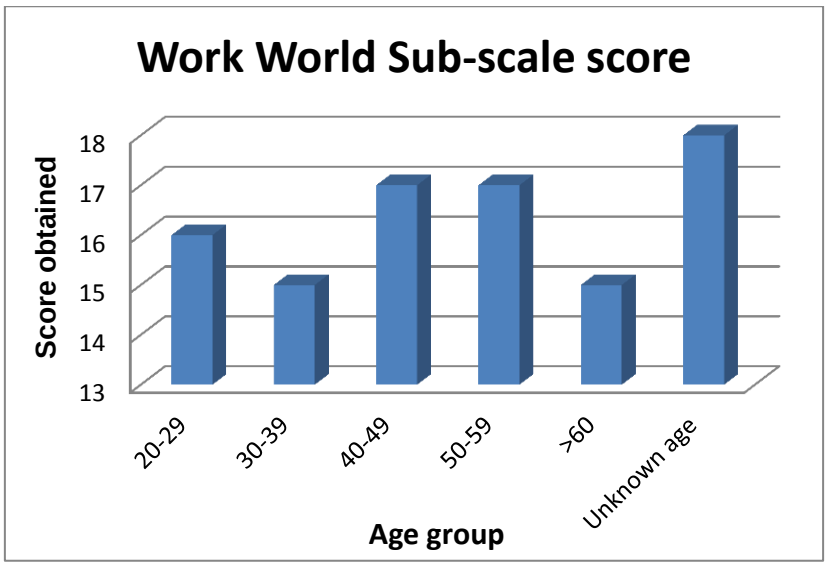


Figure 5.3: Work world by age groups (n=58)

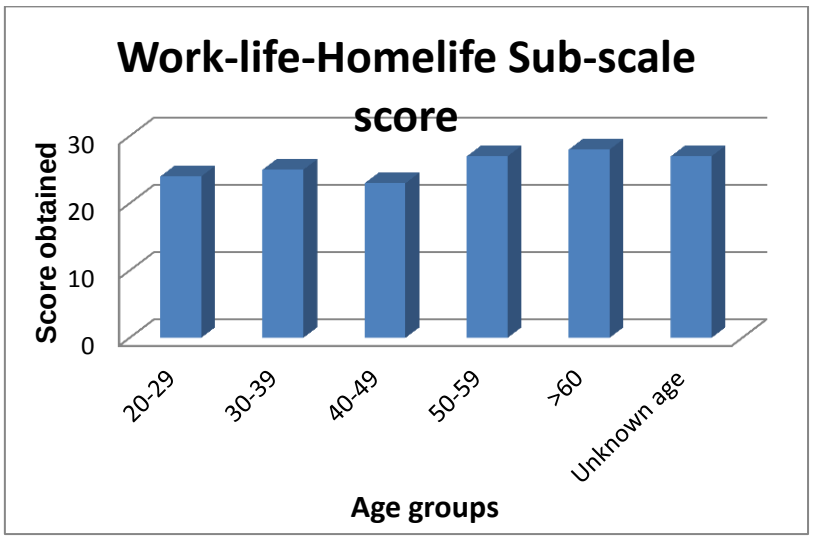


Figure 5.4: Work-life – Home-life by age groups (n=58)

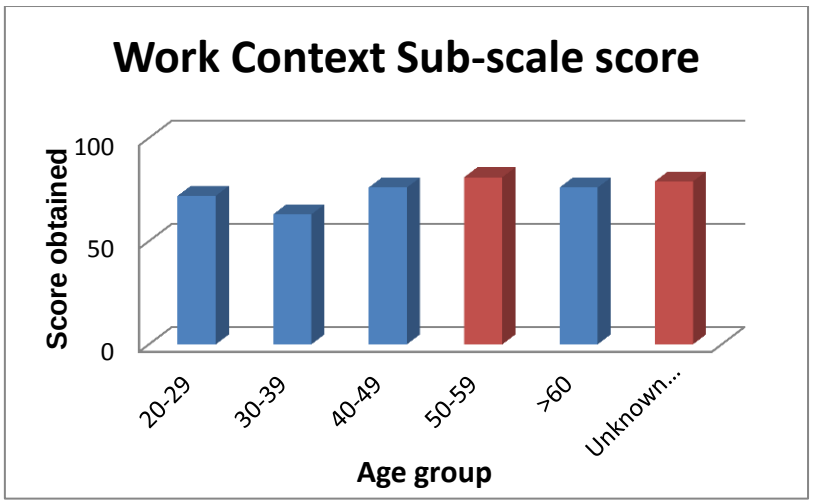


Figure 5.5: Work context by age groups (n=58)

By analysing participants' data as a whole, the following findings were noted:

The majority of the midwives experienced an overall moderate quality of work-life (73%, n=42). These included mostly moderate scores in all four sub-scales (Figure 5.6).

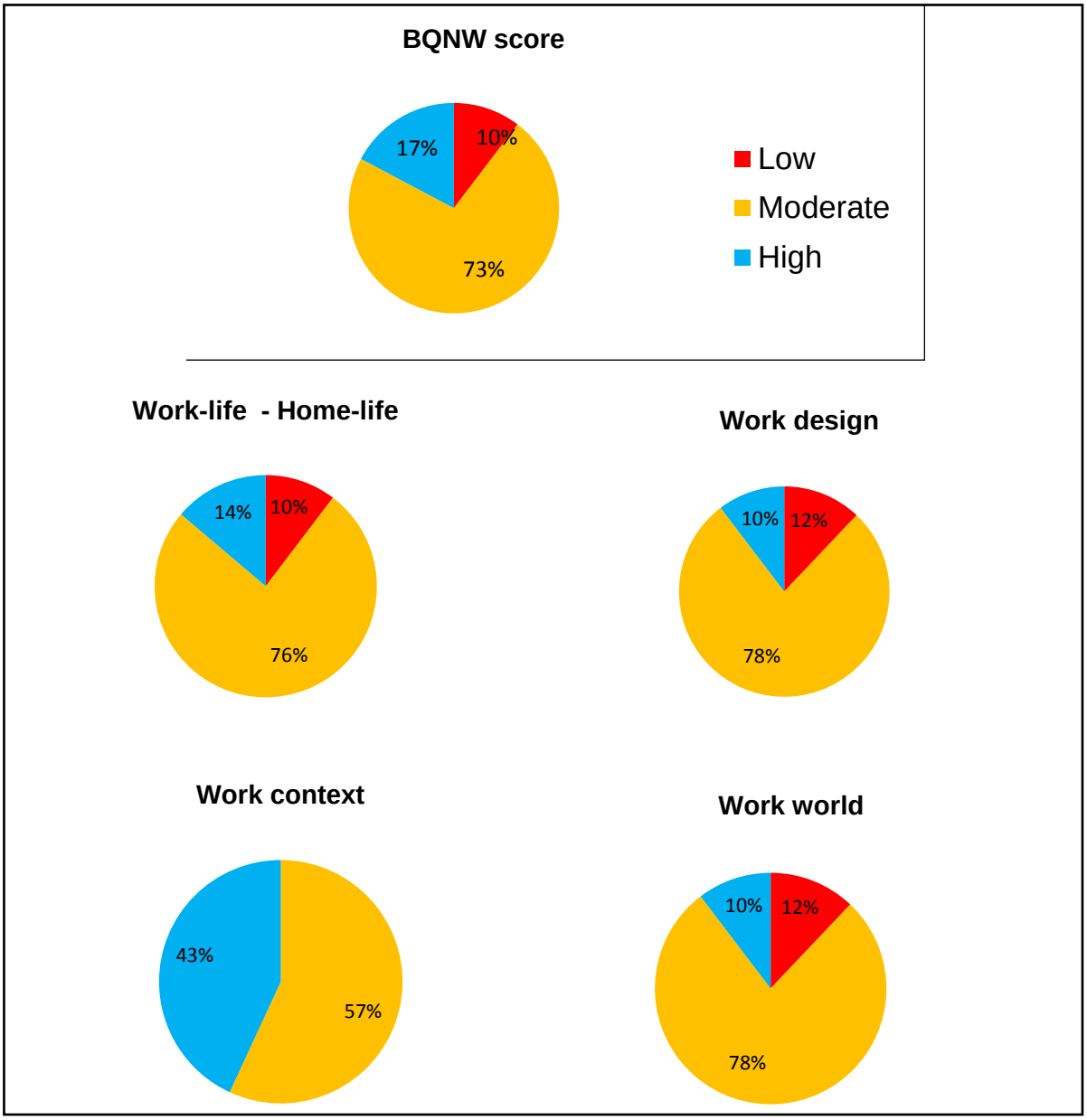


Figure 5.6: Group analysis (n=58)

Further analysis of individual items answered in the questionnaire was done by dividing the Likert scale ratings into two general areas of "disagree" (Likert ratings of 1, 2 and 3) and "agree" (Likert ratings of 4, 5 and 6) (Table 5.4). The following findings were noted and were highlighted per sub-scale of the BQNW questionnaire:

Under sub-scale #1, Work-life – Home-life items, 72% (n=42) of the participants disagreed that they had energy left after work and 64% (n=37) also disagreed that their organisation's policy for family-leave time was adequate. Most midwives agreed that it was important to offer employees on-site childcare services (83%, n=48), as well as leave when their children are ill (78%, n=45).

Sub-scale #2, Work design, showed that 71% (n=41) of midwives indicated they did not have a sufficient amount of assistance form support personnel such as housekeeping and nursing assistants. It was also noted that the majority of participants had to perform many non-midwifery tasks (74%, n=43). More than half of the participants (57%, n=33) indicated that they were not completely satisfied with their jobs and that they did not have enough time to do their jobs well (60%, n=35). A high number of participants (78%, n=45) experienced their workload to be too heavy and that there were not enough midwives in their work settings (93%, n=54). More than three-quarters of participants (79%, n=46) appeared to experience autonomy when making patient care decisions.

Sub-scale #3, Work context, showed that 81% (n=47) of participants did not agree to having adequate patient care supplies and equipment and 47% (n=27) did not experience that their nurse manager or supervisor provided adequate supervision. Most participants indicated that friendships with their co-workers were important to them (79%, n=46) and that there was teamwork in their work setting (74%, n=43). Most of the participants (88%, n=51) indicated that it was important to have a designated, private break area for midwives. With regards to learning and development, majority of the participants revealed that having degree-granting programmes available was important (93%, n=54), while 71% (n=41) showed that they received support to attend in-services and continuing education programmes. The percentage of midwives who indicated that policies and procedures facilitated their work was 78% (n=45). Most participants (76%, n=44) agreed that they were able to communicate well with their nurse manager or supervisor, however, they did not agree that upper-level management had respect for midwifery (71%, n=41). It was also noted that 72% (n=42) did not agree to feeling safe from personal harm (physical, emotional, or verbal) at work.

Sub-scale #4, Work world, revealed that most participants did not agree that society had an accurate image of them in general (76%, n=44). A large majority of participants did not agree that their salary was adequate for their job, given the current job market conditions (93%, n=54) and more than half (55%, n=32) agreed that they would be able to find a similar job in another organisation with about the same salary and benefits. However, majority of participants believed that their work impacts the lives of patients/families (81%, n=47).

Table 5.4: BQNW section one item summary

Item Nr.	Item Descriptions	Number of participants (n)		Percentage (%)	
		Disagree	Agree	Disagree	Agree
Sub-scale #1 Work-life – Home-life items					
5	I am able to balance work with my family needs.	30	28	52%	48%
10	It is important for a hospital to offer employees on-site childcare services.	10	48	17%	83%
12	I have energy left after work.	42	16	72%	28%
20 RC	Rotating schedules negatively affect my life.	27	31	47%	53%
25	My organisation's policy for family-leave time is adequate.	37	21	64%	36%
27	It is important for a hospital to offer employees on-site day care for elderly parents.	31	27	53%	47%
36	It is important for a hospital to offer employees on-site ill child care services.	13	45	22%	78%
Sub-scale #2 Work design items					
1	I receive a sufficient amount of assistance from unlicensed support personnel (the dietary aides, housekeeping, patient care technicians, and nursing assistants).	41	17	71%	29%
2	I am satisfied with my job.	33	25	57%	43%
3	My workload is too heavy.	13	45	22%	78%
6	I have the autonomy to make patient care decisions.	12	46	21%	79%
11	I perform many non-nursing tasks.	15	43	26%	74%
16	I experience many interruptions in my daily work routine.	27	31	47%	53%
17	I have enough time to do my job well.	35	23	60%	40%
18	There are enough Registered Nurses in my work setting.	54	4	93%	7%
23	I am able to provide good quality patient care.	20	38	34%	66%
42	I receive quality assistance from unlicensed support personnel (the dietary aides, housekeeping, patient care technicians, and nursing assistants).	39	19	67%	33%

Sub-scale #3 Work context items					
7	I am able to communicate well with my nurse manager/supervisor.	14	44	24%	76%
8	I have adequate patient care supplies and equipment.	47	11	81%	19%
9	My nurse manager/supervisor provides adequate supervision.	27	31	47%	53%
13	Friendships with my co-workers are important to me.	12	46	21%	79%
14	My work setting provides career advancement opportunities.	26	32	45%	55%
15	There is teamwork in my work setting.	15	43	26%	74%
19	I feel a sense of belonging in my workplace.	26	32	45%	55%
21	I am able to communicate with the other therapists (physical, respiratory, etc.).	23	35	40%	60%
22	I receive feedback on my performance from my nurse manager/supervisor.	34	24	59%	41%
26	I am able to participate in decisions made by my nurse manager/supervisor.	30	28	52%	48%
28	I feel respected by physicians in my work setting.	28	30	48%	52%
29	It is important to have a designated, private break area for the nursing staff.	7	51	12%	88%
30	It is important to me to have nursing degree-granting programmes available at my hospital.	4	54	7%	93%
31	I receive support to attend in-services and continuing education programmes.	17	41	29%	71%
32	I communicate well with the physicians in my work setting.	21	37	36%	64%
33	I am recognised for my accomplishments by my nurse manager/supervisor.	31	27	53%	47%
34	Nursing policies and procedures facilitate my work.	13	45	22%	78%
35	The security department provides a secure environment.	33	25	57%	43%
38	I feel safe from personal harm (physical, emotional, or verbal) at work.	42	16	72%	28%
40	Upper-level management has respect for nursing.	41	17	71%	29%
Subscale #4 Work world items					
4	In general, society has an accurate image of nurses.	44	14	76%	24%
24	My salary is adequate for my job given the current job market conditions.	54	4	93%	7%
37	I would be able to find my same job in another organisation with about the same salary and benefits.	26	32	45%	55%
39	I believe my job is secure.	24	34	41%	59%
41	My work impacts the lives of patients/families.	11	47	19%	81%

5.3 Discussion

Findings from the quantitative data revealed numerous aspects that were associated with motivating factors and challenges influencing the retention of midwives. It was a concern to note that challenges identified far outweighed the motivating factors associated with items of the BQNW.

Motivating factors were related to the following findings: Many participants reported that they were able to practice autonomously when making patient care decisions. Being able to work autonomously was understood as a motivating factor that may potentially increase the retention of midwives (Hildingsson & Fenwick, 2015; Versaevel 2011). Another motivating factor that may facilitate retention was noted when most participants indicated that friendships with co-workers were important and that there was teamwork in their work settings. Sullivan et al. (2011) found that positive work relationships motivated midwives and in so doing, enhanced retention.

Additionally, Adegoke et al. (2015) and Wurie et al. (2016) found that midwives were motivated by training opportunities. This was consistent with a vast majority of participants indicating that it was important to have degree-granting programmes available. Most of the participants also indicated that their worked impacted the lives of patients and/or families. Versaevel (2011) indicated that being able to make a difference positively motivated midwives and as a result enhanced job satisfaction.

Challenges that may influence retention of midwives were related to the following findings: Most participants conveyed that they did not have energy left after work. This may be related to feelings of impending burnout, as Creedy et al. (2017) identified that burnout was related to continuous exposure to stressors and was characterised by emotional exhaustion and physical fatigue. Moreover, Creedy et al. (2017) elaborated that burnout decreased emotional well-being, which inadvertently may decrease retention of staff (Wright & Bonett, 2007).

It was also noted that a substantial number of participants reported they received insufficient assistance from support personnel and had to fulfil many non-midwifery tasks. Holland et al. (2018) and Ith et al. (2012) identified that added administrative tasks were challenges midwives faced and this influenced their working

environments negatively. A major concern was noted when more than half of the participants reported that they were not fully satisfied with their jobs. Findings by Mokoka et al. (2011) and Sullivan et al. (2011) indicated that job satisfaction played a key role in staff retention. It was also noted that the majority of the participants reported that their workload was too heavy. In previous literature, this was identified as a challenge that influenced staff retention (Holland et al., 2018; Pugh et al., 2013). Most participants also reported that there were not enough midwives in their work settings, indicating staff shortages that further exacerbated a heavy workload. This was a critical issue to address as staff shortages and were documented as a contributing factor towards midwives' intentions to leave their jobs, thus influencing retention (Curtis et al., 2006; Hildingsson & Fenwick, 2015; Holland et al., 2018; Pugh et al., 2013).

Other findings from the BQNW revealed that the majority of participants reported they had inadequate patient supplies and equipment. This was identified in previous studies as a workplace challenge influencing the retention of midwives (Adegoke et al., 2015; Bonenberger et al., 2014; Ith et al., 2012).

Nearly half of the participants indicated that they were not always able to participate in decisions made by nurse managers. This was identified as a challenge influencing retention of midwives in previous studies (Holland et al., 2018; Ith et al., 2012). Ith et al. (2012) reported that supportive management positively influenced the retention of staff. Alternatively, a lack thereof negatively affected the intention to remain practising (Curtis et al., 2006; Hood et al., 2010; Wurie et al., 2016). Thus, it was alarming to note that most participants perceived that upper-level management did not have respect for midwifery.

Moreover, other findings showed that the majority of participants did not agree that they received an adequate salary. Financial incentives and benefits were identified as challenges encountered by midwives in previous studies and influenced their intention to leave (Bonenberger et al., 2014; Mansoor et al., 2013; Pugh et al., 2013; Sullivan et al., 2011; Wurie et al., 2016). Furthermore, just less than half of the participants showed that they do not believe their job is secure. This was an issue as

Holland et al. (2018) indicated that job security was one of the reasons midwives remained in their work settings.

Overall, quantitative findings pointed out both motivating factors and workplace challenges that are to be taken into account when addressing the retention of midwives in MOUs.

5.4 Conclusion

The chapter described demographic information of the participants who completed the self-administered questionnaires in full. A total of 58 questionnaires were analysed and descriptive statistics were calculated. These statistics were analysed according to age groups and overall participants per questionnaire sub-scale scores were obtained. Further analysis of individual items in the questionnaire was discussed according to the sub-scales.

In the next chapter, the integration of the scoping review, qualitative and quantitative data findings will be discussed according to the Conceptual Framework for Predicting Nurse Retention (CFPNR) (Sawatzky & Enns, 2012).

CHAPTER SIX: INTEGRATION OF DATA FINDINGS AND DISCUSSION

6.1 Introduction

This chapter describes the Conceptual Framework for Predicting Nurse Retention (CFPNR) by Sawatzky and Enns (2012). This framework guided the discussion and integrated the findings related to the scoping review, qualitative and quantitative data.

6.2 Conceptual Framework for reporting findings

The CFPNR by Sawatzky and Enns (2012) was initially created to provide a theoretical context for the key predictors of retention of emergency nurses. The CFPNR consists of the relations between influencing and intermediary factors of nurses' intention to leave. According to Sawatzky and Enns (2012), there is a significant relationship between these two sets of factors. Influencing factors may predict the intention to leave one's job directly or indirectly, depending on their effect on intermediary factors. Whilst intermediary factors may affect influencing factors, they may also have a direct impact on one's intention to stay or leave. This framework was developed from findings of similar studies and models. These studies included research done by Stone, Larson, Mooney-Kane, Smolowitz, Lin and Dick (2006), which identified six factors of organisational climate and was incorporated into the CFPNR. Influencing factors relating to organisational climate consist of professional practice; staffing and resources; nursing management; nurse/physician collaboration; nursing competence; and positive scheduling climate. Influencing factors also included personal factors, such as demographics. Intermediary factors included job satisfaction; engagement; professional quality of life; and caring. These factors were shown to influence nurses' intentions to leave and thus influence the retention of staff. Discussion of findings related to the scoping review, qualitative and quantitative data were guided according to the influencing and intermediary factors of the CFPNR.

6.3 Integrated data findings and discussion

It was noted that influencing and intermediary factors have a significant relationship. As a result, aspects associated with influencing factors may overlap as intermediary factors as well.

Influencing factor: Professional practice

Stone et al. (2006) provided a description of the professional practice that is incorporated into the CFPNR and states that it related to the opportunities for advancement and being involved in institutional governance. Findings from the scoping review indicated that midwives who work on a permanent basis were challenged by a lack of career advancement opportunities (Holland et al., 2018), whilst quantitative data findings showed that more than half of the participants (55%, n=32) did not agree that their work settings provided career advancement opportunities.

Furthermore, professional practice may relate to participants' views on policies, protocols and guidelines. Participants claimed that guidelines were not always clear or available and participants were dissatisfied with not being part of the decision-making processes involved with protocols. Quantitative data findings indicated that 52% (n=30) of participants did not agree with the questionnaire item of being able to participate in decisions made by their nurse managers or supervisors. Reviewed literature by Holland et al. (2018) and Ith et al. (2012) found that midwives were demotivated in their workplaces when they were not heard or part of teams involved in decision-making processes. It was important for midwives to be included in these processes as policies and procedures facilitate how they work, as agreed upon by 78% (n= 45) of the participants.

Influencing factor: Staffing and resources

A lack of staffing and resources was predominantly mentioned by participants during the qualitative in-depth interviews. With regard to staffing, the majority of the participants mentioned how staff shortages influenced not only an existing high workload, but also influenced the quality of care they rendered to their patients. Furthermore, it also influenced their intentions to leave. This corresponded with quantitative data findings, specifically Sub-scale #2 – Work design items. More than

three-quarters of participants (78%, n=45) agreed that their workload was too heavy, whilst 93% (n=54) of the participants disagreed with the statement that there were enough registered midwives in their work settings. However, conversely, it was also noted that more than half (66%, n=38) of the participants agreed with the statement that they were able to provide good quality patient care. Findings by Curtis et al. (2006), Hildingsson and Fenwick (2015), Holland et al. (2018), and Pugh et al. (2013) indicated that staff shortages, insufficient staff-to-patient ratios and high workloads were challenges experienced by midwives participating in their studies.

Participants in this study further explained that a combination of staff shortages and high workload lead to burnout. This was an intermediary factor identified by Sawatzky and Enns (2012) in the CFPNR. A few participants reported that the recruitment of younger midwives would address the issue of staff shortages. Other participants indicated that assistance from other categories of nurses and administrative staff was a challenge and would assist with their high workload if addressed by management. This correlated with quantitative data findings that indicated that 71% (n=41) of the participants disagreed about receiving a sufficient amount of assistance from support personnel, which influenced the quality of work-life.

The qualitative data also indicated that due to poor staffing, participants were challenged by additional administrative responsibilities as there were few, if any administrative clerks. Findings from the quantitative data corresponded with this, as nearly three-quarters of the participants (74%, n= 43) agreed to performing many non-midwifery tasks. Likewise, Holland et al. (2018) and Ith et al. (2015) found that additional administrative duties were a challenge midwives encountered and this intensified their workloads.

Influencing factor: Nursing management

Stone et al. (2006:1908) referred to the factor of nursing management as “perceptions of the nurse manager”. During the in-depth interviews, it was noted that a few participants expressed they felt motivated by the support from their managers. However, it was more often indicated that they felt frustrated by the lack of support from their managers and upper management. Quantitative data findings from the questionnaire revealed that 76% (n=44) of participants felt they were able to

communicate well with their nurse managers or supervisors, whilst 53% (n=31) indicated that they were provided with adequate supervision. However, 71% (n=41) of participants disagreed with the item that stated upper-level management had respect for midwifery. Studies by Curtis et al. (2006), Hood et al. (2010), and Wurie et al. (2016) indicated that a lack of supportive management and supervision was an issue experienced by midwives. Curtis et al. (2006) further revealed that midwives indicated a lack of support from management to be one of the main reasons to leave the profession, thus influencing the retention of midwives.

Qualitative findings also identified participants' fear of litigation related to maternal child complications. Findings further showed that participants did not feel supported by management when faced with possible litigations. Scoping review findings indicated that midwives felt unprotected and ill-informed by management, whilst being left to fend for themselves when faced with reviews that had legal proceedings related to it. It was further explained that litigations negatively impact on the midwives' personal lives and influenced their intentions to leave the profession (Hood et al., 2010).

Participants further revealed they did not receive adequate psycho-social support from management. This form of support included the use of wellness programmes, debriefing, counselling, and mentoring. Even though there were wellness programmes in place, not all participants were aware of it. A study by Creedy et al. (2017) identified that impaired emotional well-being was related to burnout and associated workplace stressors. It asserted that the emotional well-being of midwives was to be addressed as it had implications towards safe and satisfactory patient care, as well as the retention of midwives. Moreover, qualitative findings showed that participants were demotivated and felt unsupported by a lack and oftentimes absence of debriefing and mentoring from management. This was reinforced by Adegoke et al. (2015), as well as Hildingsson and Fenwick (2015) who revealed that mentorship would be beneficial to midwives. Hildingsson and Fenwick (2015) further suggested that mentorship of newer qualified midwives by more experienced midwives would facilitate with retention of staff.

Influencing factor: Nurse/physician collaboration

This factor related to the collaboration between midwives, as well as with physicians. Qualitative findings showed that participants feel that the challenge of staff shortages may be overcome with teamwork and implied that there was a lack thereof. In contrast, it was noted from the quantitative data findings that the majority of midwives (74%, n=43) agreed that teamwork was already existing in their work settings. Scoping review findings showed that midwives were motivated by having positive working relationships with colleagues (Sullivan et al., 2011).

Collaboration between midwives and physicians was also mentioned by participants during the in-depth interviews. They indicated that when they seek assistance from physicians, it was not always readily available. Quantitative data findings showed that 64% (n=37) of participants agreed that they communicate well with physicians, however, this did not necessarily indicate that they receive the support they required. Crowther et al. (2018) and Versaevel (2011) found that midwives viewed relationships with non-midwifery staff, including physicians as a source of stress at times. Versaevel (2011) further asserted that while non-midwifery colleagues may be supportive, improving working relationships would positively influence the retention of midwives.

Influencing factor: Nursing competence

This factor was closely related to the sub-theme of learning and development identified from the qualitative data. Participants reported that they were seldom provided with the opportunity to undergo advanced midwifery training that may improve their clinical competency skills. However, they were provided with the opportunity to attend skill development training sessions. This was consistent with quantitative data findings, according to which 71% (n=41) of the participants agreed to the statement that they received support to attend in-services and continuing education programmes. Participants reported that they would be motivated if they could study further. This was consistent with quantitative data findings that showed 93% (n=54) of participants agreed that having degree-granting programmes available at their institution was important. As a result of having to wait their turn to study further, they relied on their existing knowledge and experience in the meantime. Findings from the scoping review revealed that midwives seek learning and

development opportunities and a lack thereof may influence the retention of midwives (Adegoke et al., 2015; Bonenberger et al., 2014; Ith et al., 2012; Pugh et al., 2013; Wurie et al., 2016).

Influencing factor: Positive scheduling time

During qualitative interviews, participants relayed that a shortage of staff resulted in dissatisfaction with interdepartmental shifts and duty allocations. One participant conveyed discontent with her off-duties as this was one of the reasons for her intent to leave before she retired. Quantitative data findings indicated just over half of participants (53%, n=31) agreed that rotating schedules negatively affected their lives.

Influencing factor: Person factors

This factor in the CFPNR looked at demographic factors. These factors included "gender, age, education, employment status, shift rotation" type of work institution, how long they have been practising, their household income, and additional caregiving responsibilities at home (Sawatzky and Enns, 2012). From the demographic data in the quantitative questionnaires, it was noted that more than half of the participants were between the ages of 40 and 59 years (n=36, 62%) and were responsible for the care of their (and/or their spouse/partner's) elderly parents (53%, n=31). Pugh et al. (2013) reported that for a few midwives, personal family commitments were challenging and may influence the retention of midwives. Furthermore, Sawatzky and Enns (2012) stated that older age was a substantial factor that influenced the intention to leave. With regard to shift rotation, the majority of the participants indicated that they rotate shifts (78%, n=45), however, just more than a quarter (26%, n=15) reported that they received compensation for rotating shifts.

Intermediary factors: Job satisfaction

The qualitative data findings indicated that participants experienced satisfaction from work as a result of intrinsic and extrinsic factors. Intrinsic factors included feeling satisfied when assisting during the birth of a healthy baby or when they felt they made a difference. This was consistent with scoping review findings. Sullivan et al. (2011) and Versaevel (2011) found that job satisfaction was one of the reasons

midwives remained in the profession. Versaevel (2011) further indicated that job satisfaction resulted from different contributors, including being able to make a difference. Participants also reported that they were motivated by being able to manage complications and work independently. This correlated with findings in the literature that indicated that midwives were motivated by job satisfaction when related to the ability to work autonomously (Hildingsson, et al., 2015; Versaevel, 2011). Corresponding quantitative findings showed that 79% (n=46) of participants agreed that they had the autonomy to make patient care decisions. According to Wright and Bonett (2007) job satisfaction was influenced by employee well-being, which in turn was related to the quality of work-life (Chan & Wyatt, 2007). Overall analysis of the quantitative data indicated that participants perceived their quality of work-life at a moderate level.

Intermediary factors: Engagement

The CFPNR factors of engagement are in line with the six contributors of engagement found in the Hewitt Engagement Model (Hewitt Associates, 2008 cited in Sawatzky & Enns, 2012). These factors included people, work motivation, opportunities, quality of life, procedures, and total rewards. People referred to staff engagement with management and co-workers. As mentioned previously, participants perceived teamwork as a means of overcoming challenges, whilst aspects related to managerial support and acknowledgement influenced the retention of midwives.

According to Sawatzky and Enns (2012), work motivation may relate to intrinsic drive, the availability of resources and work tasks. Intrinsic drive and work tasks were described during the discussion of the CFPNR influencing factors. A significant challenge mentioned by most participants was the provision of well-maintained equipment and material resources. Quantitative findings indicated that the majority of the participants (81%, n=47) did not agree to having adequate patient care supplies and equipment. Adegoke et al. (2015), Bonenberger et al. (2014), and Ith et al. (2012) confirmed that a lack of medical supplies and well-maintained equipment negatively impacted midwives' working conditions and thus to an extent their quality of work-life. However, this was contended by Blaauw et al. (2013) who found that despite South Africa having better resources, staff ratios and working conditions,

health care workers including midwives still displayed the lowest levels of satisfaction and highest turnover intentions.

Sawatzky and Enns (2012) further indicated that opportunities related to career, learning and development opportunities, whilst the quality of life-related to work-life balance and physical work environment. Development opportunities and work-life balance have also been discussed with other influencing factors. The physical work environment related to the qualitative sub-theme of safety and security. Participants reported that the environment within which they worked was not always safe for their patients or themselves. Quantitative data findings showed that 72% (n=42) of participants did not feel entirely safe from personal harm at work. This included safety from physical, emotional or verbal harm. Other forms of a safe environment included being safe from infection. Due to a lack of supplies, infection prevention measures were not always maintained. Scoping review findings further revealed that a high workload and added administrative work, left skilled birth attendants not always having the time or feeling too tired to clean, thus increasing the susceptibility for cross-contamination and infection (Ith et al., 2012).

The Hewitt Engagement Model (Hewitt Associates, 2008 cited in Sawatzky & Enns, 2012) was consistent with the CFPNR, as it also included factors related to total rewards. These were referred to as pay, benefits, and recognition by Sawatzky and Enns (2012). Qualitative findings showed that a lack of financial incentives and benefits was a frustration and concern. These financial incentives included night duty and speciality allowances. Quantitative findings revealed that a vast majority of participants (93%, n=54) did not agree that their salary was adequate for their jobs, given the current market conditions. Furthermore, 55% (n= 32) of participants agreed that they would be able to find a similar job in another organisation with about the same salary and benefits. Ith et al. (2012) found that midwives were positively motivated by financial incentives. Findings by Bonenberger et al. (2014), Mansoor et al. (2013), Pugh et al. (2013), Sullivan et al. (2011) and Wurie et al. (2016) inferred that addressing financial issues and concerns could have the potential to influence retention of midwives.

Moreover, some participants reported that they would be more motivated if management provided recognition or acknowledgement for the work they do. This correlated with findings by Bonenberger et al. (2014) and Ith et al. (2012) whose studies indicated that recognition from management and society motivated midwives. Quantitative data findings from the questionnaire indicated that less than half of the participants (47%, n=27) felt recognised for their accomplishments by their nurse managers or supervisors.

Holland et al. (2018) revealed that engagement was also influenced by a lack of employee voice. Employee voice related to staff being able to voice their concerns and be a part of decision-making processes. In turn, this was affected by staff meetings. Qualitative findings indicated that multi-disciplinary meetings were held on a monthly basis in an attempt to address issues. Crowther et al. (2018:5) stated that "Good working relationships with local GPs, nurses, paramedics and other health care professionals provide opportunities for professional discussion, debriefing and sharing of resources."

Intermediary factors: Professional quality of life

According to Sawatzky and Enns (2012), professional quality of life consisted of compassion satisfaction, compassion fatigue and burnout. Compassion satisfaction was described as satisfaction from being able to do one's job well, whilst compassion fatigue was associated with prolonged exposure to stressors from caring (Sawatzky and Enns, 2012). Compassion satisfaction is closely related to intrinsic drive, which was discussed with the intermediary factor of engagement. Aspects linking to compassion fatigue were noted in qualitative findings. Participants expressed feelings of discouragement when faced with conflict from the community and patients. A study related to the retention of health care workers, including midwives, indicated that health care workers were positively motivated by being able to serve their community and when they were appreciated (Wurie et al., 2016). However, Wurie et al. (2016) commented that community relationships were at times viewed in a negative light as participants felt they had to work under the scrutiny of the community. Holland et al. (2018) indicated that midwives were troubled by having to put on a false façade for patients, which was emotionally taxing. Furthermore,

qualitative findings indicated that participants experienced burnout, which consequently exacerbated compassion fatigue (Sawatzky and Enns, 2012).

Intermediary factors: Caring

This factor was closely associated with the previously discussed compassion fatigue. As staff may feel emotionally drained from caring for their patients, it was reported that they safeguard themselves by becoming detached (Sawatzky and Enns, 2012). Qualitative findings showed that participants often feel emotionally strained from the extent and context of their work, thus sought forms of psycho-social support, for example, debriefing.

Intention to leave

The outcome of intention to leave was indicated in the CFPNR when influencing factors and intermediary factors were not addressed. Qualitative findings indicated that a few participants already had intentions to leave due to work-related factors. These work-related factors mentioned by participants were consistent with factors of the CFPNR.

6.4 Conclusion

Integration and discussion of the findings from the scoping review, qualitative data and quantitative data were done according to the CFPNR developed by Sawatzky and Enns (2012). It was noted that findings from the study were consistent with influencing factors and intermediary factors that may impact one's intention to leave, thus negatively affecting the retention of midwives.

In the final chapter, the conclusion, summary, main findings, limitations and recommendations from the study will be discussed.

CHAPTER SEVEN: CONCLUSION, SUMMARY, MAIN FINDINGS, LIMITATIONS AND RECOMMENDATIONS

7.1 Introduction

Midwives play a vital role in the service delivery of maternal and newborn health care. Retention of staff is often associated with shortage of staff, as staff shortages exacerbate retention of staff and vice versa. Previous literature has indicated that a shortage of health care workers, including midwives has an impact on the delivery of health care and inadvertently influences patient outcomes. Staff shortages are frequently linked to high staff turnover and low retention rates. Low retention of midwives is often associated with job dissatisfaction, impaired employee well-being and other factors related to the quality of work-life. The purpose of the study was to explore and describe motivating factors and challenges influencing the retention of midwives, in order to provide recommendations to MOU managers and the district health system.

7.2 Summary

A concurrent mixed methodology design with the mixed method annotation QUAL+quan was used for this study. A scoping review was conducted to identify and describe literature related to the motivating factors and challenges influencing the retention of midwives. Data were collected during 30 in-depth interviews and thematically analysed according to Creswell's (2014) six steps to analysing qualitative data. In addition, questionnaires based on the existing Brooks' Quality of Nursing Worklife Survey (BQNW) were analysed to provide descriptive statistics. Qualitative and quantitative findings were integrated together with findings of the scoping review. This was done using the Conceptual Framework for Predicting Nurse Retention (CFPNR) to guide the discussion. The CFPNR consists of influencing and intermediary factors that may impact a person's intention to leave their job or current work position.

7.3 Main findings

This study explored factors that are perceived as motivating and challenging towards the retention of midwives in the public sector. These factors are associated with

Quality of Work-life (QWL) and well-being. Quality of work-life has been described as “the degree to which RNs are able to satisfy important personal needs through work experiences, while simultaneously achieving the organisation’s goals” (Brooks & Anderson, 2005:324).

Key findings from the scoping review identified motivating factors and challenges influencing retention of midwives. These findings were grouped into individual reasons, relationships and workplace aspects. Individual reasons that were motivating were job satisfaction, being effective in their roles, serving the community and receiving recognition, amongst other factors. Individual factors that posed as a challenge influencing retention of midwives were family commitments and feeling emotionally exhausted.

Motivating reasons related to relationships were that midwives felt encouraged by positive relationships with clients, their families and work colleagues. This was indicated to enhance their decision to remain practising in the profession. However, it was also noted that relationships with the community and other professions posed as a challenge at times and could influence the retention of midwives. Motivating reasons towards retention that were related to workplace aspects include training and development opportunities, improved working conditions, working autonomously, financial incentives, and supportive supervision.

Workplace challenges that influenced the retention of midwives included inadequate staffing or perceived staff shortages, high workload, burnout, the fear of litigation, increased administrative work, a lack of financial incentives and benefits, as well as not being a part of decision-making processes. Other factors that were also workplace challenges influencing retention were indicated as a lack of medical supplies and equipment, not being able to work autonomously, lack of recognition, inadequate managerial support, and a lack of permanent position or career advancement opportunities.

The literature reviewed inferred that the development of strategies to improve training, development, addressing work-related relationships, enhancing job

satisfaction and improving employee well-being would facilitate the retention of midwives.

Qualitative findings from the study identified four themes that relate to motivating factors and workplace challenges that potentially influence the retention of midwives. These themes were motivation to stay, staff shortages, the inner context, and the outer context. Most findings from the qualitative data were consistent with findings from the quantitative data and scoping review evidence. The first theme of motivation to stay identified that most midwives are intrinsically, as well as extrinsically motivated to remain practising. It is also noted that a few midwives displayed a lack of motivation, which negatively influences the retention of midwives. Intrinsic motivation relates to being able to attend births, being able to make a difference, managing complications, working independently and being self-motivated. Extrinsic motivation is derived from acknowledgement from management and receiving recognition for advanced training. A lack of motivation was noted when midwives report their intentions to leave, being involuntarily placed in midwifery settings and when waiting to go on pension. The second theme identified from the qualitative findings was staff shortages. The majority of findings related to this theme were seen as challenges that could influence the retention of midwives. These included factors associated with midwives' high workload, a lack of support from additional staff, and a lack of development opportunities. The third theme related to the inner context of the organisational environment, and included factors that are more challenging than motivating, which influences the retention of midwives. These factors included a lack of support from management and other health care professions, the negative implications related to litigations, lack of a safe environment for both midwives and their patients, as well as a lack of psycho-social support (debriefing, counselling, and mentoring). The last theme of the outer context related to challenges midwives encountered within their surrounding communities and their patients. These factors were challenges that demotivated midwives and which could negatively influence retention.

Likewise, quantitative findings identified motivating factors and challenging factors related to the quality of work-life. As previously mentioned, retention of staff is associated with the quality of work-life. Therefore, poor quality of work-life may

negatively influence the retention of midwives. Most midwives scored moderate levels for overall quality of work-life, indicating that midwives are more or less able to satisfy important personal needs at work, whilst achieving the organisation's goals at the same time. Further analysis of the quantitative data revealed motivating factors and challenges. Motivating factors identified include that midwives are able to work autonomously, having friendships with co-workers, teamwork, training opportunities and being able to impact the lives of patients and/or families. Challenges identified that could influence retention of staff included midwives not having energy left after work, insufficient assistance from support personnel, having to complete many non-midwifery tasks, and not being fully satisfied with their jobs. Other challenges also identified included a heavy workload, inadequate staffing, insufficient supplies and equipment, as well as not being able to participate in decision-making. Furthermore, challenges also included the perception that upper-level management does not respect midwifery, inadequate salaries, and a lack of job security.

Combined findings from the data indicated that midwives are generally intrinsically motivated to stay in the profession. However, they are frequently challenged by issues related to perceived staff shortages, an apparent lack of support and resources, as well as conflict within the community.

Staff shortages are shown to increase the current high workload of midwives, which is exacerbated by additional administrative tasks. These shortages also influence opportunities for further training and are associated with midwives experiencing burnout. Midwives require support from other categories of nursing staff, administrative personnel, doctors and management. However, it appears that they are seldom provided with this support, particularly by management, especially when midwives face possible litigations. Other forms of support such as recognition, acknowledgement, debriefing and counselling are also emphasised to be lacking in their workplace. Midwives highlighted the conflict they experienced from the community and patients. This involved the perception that midwives are judged and not respected by the community. It also involved the challenges when patients are uncooperative by not receiving care from designated clinics or not attending antenatal visits at all. As a result, they often feel the need to be wary of litigation and associated implications.

Other challenges included inadequate equipment and resources as this has an impact on patient health care and midwives quality of work-life. An example commonly reported includes the lack of well-maintained patient monitoring equipment. This influences patient care and outcomes by not being able to detect health care problems timeously. Furthermore, a lack of supplies such as newborn umbilical cord clamps, urine catheter bags and clean linen increases susceptibility towards infections and poor patient outcomes.

Implications of this study identified that although most midwives score moderate levels on the BQNW, it is still concerning that they are confronted with a vast array of challenges that may influence their intentions to leave or remain practising.

7.4 Limitations of the study

Limitations related to the methodology of the study were as follows:

The research study conducted included a small and limited study sample. As phase one of the study consisted of quantitative data, a representative distribution of the population may not be ensured. Secondly, the study made use of a questionnaire that was originally developed to measure the quality of work-life of staff nurses in a hospital setting. Participants of the study were midwives practising in maternity services of the public sector, specifically independently run MOUs. Although registered nurses and midwives have similar scopes of practice, midwives in MOUs are expected to practice with very little assistance from members of other health care professions. Thus, a questionnaire that is contextualised towards midwives may have provided more accurate results. Thirdly, self-reported data, which was taken at face value, may have led to a source of bias. This was noted when one of the qualitative findings related to teamwork was incongruent with quantitative data findings.

Limitations that were related to the researcher were as follows:

The researcher did not have access to each potential participant, as midwives at the MOUs rotate to night shifts, whilst others were on annual or sick leave. Another limitation that was encountered was the participants' lack of fluency in English. Although in-depth interviews were audio recorded and transcribed verbatim, there were instances when participants were inaudible or their statements were incomprehensible. The researcher ensured to do member checks during the

interview by repeating back the heard responses. However, this may have created a bias for participants to agree with what the researcher repeated.

7.5 Recommendations

While challenges such as staff shortages, lack of equipment and inadequate financial incentives are not easily remedied, other work-related factors may still be addressed. The following recommendations have been identified according to clinical practice, nursing and midwifery education and future research.

7.5.1 Recommendation for clinical practice

Recommendations include that management acknowledge and recognise midwives for their work done when done well. This may be done with frequent appraisals between midwives and their managers. It is also recommended that visibility of upper management in the MOU departments occur more frequently, in order to touch base with the midwives on the floor. As the fear of litigation is a predominant challenge encountered by midwives, it is further recommended to develop debriefing strategies and programmes facilitated by managers. These debriefing sessions are to be held regularly within midwifery teams, as well as with other professions of the health care team. This would also address different challenges associated with being supported in the workplace. Moreover, it is recommended that MOU managers include midwives in decision-making processes such as the allocation of off-duties and shifts. During these discussions, training plans for learning and development are to be developed in advance and adhered to.

7.5.2 Recommendations for education

It is recommended that nursing and midwifery programmes incorporate mentoring programmes during students' clinical placements in midwifery settings. This may positively enhance their midwifery clinical experiences and in so doing increase attraction and recruitment towards the profession. It is also recommended that midwives are to be provided with problem-solving training and taught coping skills, especially related to legal issues.

7.5.3 Recommendations for future research

Further research is recommended to explore motivating factors and challenges in other contexts, such as rural and private sectors. It would also be used to develop a contextualised questionnaire specific to the retention of midwives in the South African public setting.

7.6 Conclusion

The retention of midwives plays a vital role in the promotion of maternal and newborn health care. This is further emphasised in midwives working in the public sector whereby midwives predominantly care for low-risk patients. Motivating factors and challenges influencing the retention of midwives in the public sector have been identified and are in line with the CFPNR that describes influencing and intermediary factors impacting employees' intention to leave.

The CFPNR was developed to identify the links between these two sets of factors and the impact they have on employees' intention to leave (Sawatzky & Enns, 2012). Both sets of factors may directly or indirectly impact one's intention to stay or leave their current position or jobs. Influencing factors include aspects related to personal factors, demographics and organisational climate (professional practice, staffing and resources, the perception of management, collaboration with physicians, nursing competence and scheduling climate). Intermediary factors relate to job satisfaction, engagement, professional quality of life and caring. If motivating factors and challenges related to these influencing and intermediary factors are not addressed, this potentially affects the retention of staff.

It may be useful for MOU managers and the district health systems to address these issues related to motivating factors and challenges that midwives face. The retention of midwives in the public sector may be facilitated and enhanced with the use of the recommendations provided.

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9. ANNEXURES:

Annexure 1: Data extraction template

Full-text articles included:

Nr.	Author / Date / Title	Theoretical conceptual framework	Methodology	Implications for practice and future research	Key findings related to scoping review objective
1	Holland, P. J., Tham, T. L. & Gill, F. J (2018) Place: Australia What nurses and midwives want: Findings from the national survey on workplace climate and well-being	Factors contributing to workplace climate, well-being, career intentions and intentions to leave the profession in Australia. Both quantitative and qualitative designs were used.	An electronic survey platform: 5 tools were used to collect quantitative and qualitative data	Findings noted a potential increase in consideration for leaving the profession. Longer-term measures in improving workplace issues are to be used if the foreseen workforce shortage is to be avoided.	Inadequate nurse-to-patient ratios influence the high workload and quality of job completion. Increased administrative work responsibilities without additional time or resources add to "work intensification". High workload, inadequate opportunities for permanent positions, unfavourable working conditions, job insecurity, and ineffective voice mechanisms (i.e taking part in decision-making and team debriefings) may be leading nurses and midwives to contemplate leaving the profession.
2	Wurie, H. R., Samai, M. & Witter, S (2016) Place: Africa, Sierra Leone Retention of health workers in rural Sierra Leone: findings from life histories.	Different motivation factors in rural areas in Sierra Leone to assist with decision-making on financial and non-financial incentive packages.	The study consisted of "a health worker incentive survey, analysis of routine HR secondary data, stakeholder mapping, document review and key informant interviews, as well as the life histories". . Participants that had worked in the health sector since 2000 were selected. Midwives only consisted of 30% of the total sample.	The recommendations relate to all of the factors identified as motivators and demotivators. Strained relations with communities are harder to manage with direct policy interventions.	Data were from both urban and rural settings. Motivating - Being effective in their role, Community service, Financial incentives, Improved working conditions, Training opportunities. Demotivating factors: Difficult working conditions, Limited financial incentives and benefits, poor management, limited training opportunities and lack of career progression, political interference, strained relationships with the community, poor retention of staff. Lack of motivation can affect workers performance, health outcomes and patient safety. Other non-financial factors need careful attention. Health workers are to be a part of setting national goals, designing strategies and implementing effective policies and programmes.

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3	Takase, M., Teraoka, S. & Yabase, K (2016) Place: Asia, Japan Retaining the nursing workforce: factors contributing to the reduction of nurses' turnover intention in Japan	Investigated the effects of psychological contract fulfilment, perceived advancement opportunities and age on reducing the turnover intention of nurses in Japan.	Cross-sectional correlational design. Potential participants were 1337 registered nurses and midwives. However, only 10% were working in gynaecological/obstetric specialities. a survey questionnaire was used.	Mutual understanding regarding what has been offered and what has been received between nurses and managers is needed. Guidelines for incentives are to be used, with advancement opportunities based on employee performance and should be rewarded with training opportunities and/or advanced clinical/educational duties.	Incentives such as advancement opportunities are to provided and centred around employee performance. An advancement system is especially important for younger nurses to feel valued for their contributions. This system should be accompanied by rewards such as training opportunities and/or advanced clinical/educational responsibilities. Advancement opportunities and rewards would encourage them to stay in their organisations (Li et al. 2011).
4	Sullivan, K., Lock, L. & Homer, C. S. E (2011) Place: Australia Factors that contribute to midwives staying in midwifery: A study in one area of health service in New South Wales, Australia	Determined the factors that contribute to the retention of midwives and reasons why they stay.	Phase one used focus groups to adapt a questionnaire used in the 'Why Midwives Stay' study in England for the Australian context. Phase two used the questionnaire to collect qualitative and quantitative data. 36 midwives attended the focus groups. 204 midwives responded to the questionnaire.	Further research needs to consider the complex interactions between relationships with women, colleagues and the allegiance with the institution in relation to supporting recruitment and retention of the valuable commodity that is a midwife.	The three main reasons why midwives stay, were as follows: midwifery relationships (relationships with the women and their families and the colleagues); professional identity as a midwife (privilege of being present when women gave birth and professional pride) and, the practice of midwifery(elements of the job that midwives enjoyed, including job satisfaction and working in an area that they prefer). A few midwives would not recommend midwifery to others due to organisational, working practice, lifestyle and financial matters.
5	Bonenberger, M., Aikins, M., Akweongo, P. & Wyss, K (2014) Place: Africa, Ghana	Explored the effects of motivation and job satisfaction on turnover intention and how motivation and satisfaction can be improved by	Quantitative design - a cross-sectional survey with several staff categories (doctors, nursing professionals, allied health workers and pharmacists). The effects of motivation	A supportive supervision system should also be developed. it is, therefore, worth strengthening HRM skills at the district level	Increased motivation and job satisfaction were related to decreased risk of turnover intention. Motivation and job satisfaction were linked to career development, workload, management, organizational commitment, and burnout. Participants also conveyed to be displeased with their work environments due to the lack of

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	The effects of health worker motivation and job satisfaction on turnover intention in Ghana: a cross-sectional study	district health managers in order to increase the retention of health workers.	and job satisfaction on turnover intention were explored through logistic regression analysis. The study consisted of 256 participants which consisted of 13.3% (n=34) midwives	and supporting district health managers to implement retention strategies.	medical and technical equipment. Intrinsic and extrinsic factors were also mentioned. Career planning, in-service training and supportive supervision are also to be taken into consideration in order to meet the needs of health workers.
6	Hildingsson, I. & Fenwick, J (2015) Place: Europe, Sweden Swedish midwives' perception of their practice environment–Across-sectional study	There is a shortage of midwives in Sweden. Evidence suggests that the work environment is likely to play a part in retention and attrition rates	A cross-sectional quantitative design exploring the practice environment of midwives and factors associated with the perception of an unfavourable work environment. Questionnaires included the Practice Environment Scale (PES), the Copenhagen Burnout Inventory (CBI) and the General Self-Efficacy Scale (GSE) was used to measure burnout. the use of a scale developed in nursing and used in midwifery may be a limitation	Identified internal personality factors, as well as work related factors associated with practice work environment, is to be addressed to create positive workplaces.	Background and work-related factors were addressed. Midwives >40years and with more than 10 years' experience were more likely be a part of decision-making in their work settings. Increased years of experience and age have been found to possibly enable midwives to have a more accurate outlook on their work environment and have enhanced coping mechanisms to manage work demands. Younger and newer qualified midwives may benefit from mentorship by experienced midwives, in order to increase the retention rates and make midwives stay in the profession. Personal and/work related burnout was related to less favourable work environments. Work-related factors: Feeling supported and valued by managers, develop ing longitudinal relationships with women, experience a sense of autonomy and flexibility, and establish positive relationships with peers. Moreover, role conflict, inadequate staffing and unsupportive management are reasons why midwives leave the profession.
7	Blaauw, D Ditlopo, P Maseko, F Chirwa, M Mwisongo, A Bidwell,	Comparing job satisfaction and intention to leave of different categories of health workers in Tanzania, Malawi,	A quantitative cross-sectional survey with a self-administered questionnaire on a 10-item job satisfaction scale and one question on intention	This study has implications towards a more detailed comparative HRH research. Our findings highlight the need for	The lowest job satisfaction and highest intention to leave were found in South Africa more than 40% were dissatisfied with their jobs and actively seeking other jobs. . Even though SA has better general living standards, resources and working conditions

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	Thomas, S Normand, C (2013) Place: Africa, Tanzania, Malawi, and South Africa Comparing job satisfaction and intention to leave of different categories of health workers in Tanzania, Malawi, and South Africa	and South Africa	to leave. Multiple regression was used. Midwives were part of the sample; however no specification of how many were included as they were combined with nursing staff and other health care workers. The researchers were not able to confirm significant differences in job satisfaction or intention to leave between different health worker cadres and did collect detailed data on possible determinants, actual working conditions or remuneration.	less standardised and more targeted HRH strategies than has been the practice to date	that are related to a higher health expenditure and better staff ratios, these participants still displayed the lowest levels of satisfaction and highest turnover intentions. These differences between countries may be influenced by other aspects besides job satisfaction and working condition factors and may be cultural, economic and political in nature such as employee expectations, organisational culture, labour market conditions, as well as the organisation and militancy of health professionals.
8	Creedy, D. K., Sidebotham, M., Gamble, J Pallant, J. & Fenwick, J (2017) Place: Australia Prevalence of burnout, depression, anxiety and stress in Australian midwives: a cross-sectional survey	Investigation of the prevalence of burnout, depression, anxiety and stress in Australian midwives with the consideration for workforce retention and quality care	An online quantitative survey with standard measures included the Copenhagen Burnout Inventory (CBI) (Personal, Work and Client sub-scales), and Depression, Anxiety, and Stress Scale (DASS). Effect size statistics were analysed.	The stress associated with interpersonal professional conflict is seen as a primary contributor and consequence of burnout and requires further investigation. Different work contexts are to be investigated in relation to the prevalence of burnout.	The emotional well-being of midwives have implications for safe and satisfactory maternity care and staff retention. Emotional well-being is influenced by workplace burnout. A few causes for workplace burnout mentioned include a lack of autonomy and the use of caseload models of work. Unlike previous studies, Henriksen and Lukasse found shift work, hours worked and workload contributed little to burnout.
9	Adegoke, A. A., Atiyaye, F. B., Abubakar, A. S., Auta, A. & Aboda, A (2015)	This study aimed to determine job satisfaction and identify factors that affect retention of MSS midwives	Mixed method approach. Quantitative surveys with qualitative focus group discussions and in-depth interviews. Midwives from the National	Not mentioned	Although this study focused on MSS midwives who only work on a 1 to 2-year contractual basis, a few findings may serve useful with regard to workplace motivating factors (pull factors) and challenges (push factors) related to retention. Motivating factors: educational

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	Place: Africa, Nigeria Job satisfaction and retention of midwives in rural Nigeria.	deployed to rural areas of Nigeria. The push and pull framework is widely used to discuss the retention of staff and was applied to this study.	Midwifery Service Scheme (MSS) were sampled. These are retired, unemployed and newly graduated midwives allocated in PHC centres in rural Nigeria. These midwives work on a 1 to 2-year contractual basis		opportunities (post basic nursing), funding for post-basic education programme and promotion amongst other factors. Challenges: furthering education, lack of promotional opportunities, poor and/or irregular allowances and working environment not being conducive, amongst other challenges. It was mentioned that advice, support and mentorship may have been beneficial to the MSS midwives with varying years of experience.
10	Crowther, S., Deery, R., Daellenbach, R., Davies, L., Gilkison, A., Kensington, M. & Rankin, J (2018) Place: Europe, Scotland and New Zealand Joys and challenges of relationships in Scotland and New Zealand rural midwifery: A multicentre study	The study discussed the significance of relationships in rural midwifery and provides insights to inform midwifery education.	Qualitative data were generated from a multi-centre study using online surveys and discussion groups Social capital became a theoretical framework to was to understand how these relationships functioned in rural maternity.	Acknowledgement by senior leaders/ managers and policy-makers that relationships and the time invested in these relationships is important for all midwives and is particularly vital for rural midwives	Examination of rural maternity in New Zealand does suggest that there are communication tensions between professional groups which may be causing stress for some rural midwives again highlighting the significance of working relationships in rural practice.
11	Hood, L., Fenwick, J. & Butt, J (2010) Place: Australia A story of scrutiny and fear: Australian midwives' experiences of an external review of obstetric services,	Describes Australian midwives' experiences of an external review of obstetric services, involvement in legal proceedings and the impact on midwives' clinical practice and personal wellbeing	a qualitative study using an explorative descriptive design. Snowball sampling was used to invite 16 Australian midwives to participate in a tape-recorded interview. Thematic analysis and the techniques associated with constant comparison were used to analyse the data	Strategies are to be put in place to assist midwives with the 'emotion work' associated with their jobs, in order to ensure midwives lead midwifery care for the well-being of women and their babies. Institutions are to empower midwives and	They reported to also feel unprotected and ill-informed by management and other shifts, whilst being left to fend for themselves when faced with service delivery reviews that had legal proceedings related to it. These midwives reported feeling fear, frustration, intimidation and a lack of support when faced with litigation processes. At times these processes also left them feeling personally targeted and upset when apparent dishonesties were told by others. It was also noted that the fear of litigation leads to some midwives intention to leave the profession

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	being involved with litigation and the impact on clinical practice			their profession with evidence-based strategies that enable them to maintain their full scope of practice, whilst reinforcing the "belief in women's ability to birth normally".	altogether. Involvement in litigations had an impact on their personal lives and a "fear-culture" of litigation has been instilled when working in labour wards, which in turn has influenced their working environments and daily practices. Professional relationships within midwifery teams, other members of the health care team and mothers were also impacted. Whilst some midwives reported that they appreciated assistance and input from doctors, others reported that this hinders midwives ability to carry out their full scope of practice and advocate for women during low-risk normal births.
12	Ith, P., Dawson, A. & Homer, C. S.E (2012) Place: Asia, Cambodia Challenges to Reaching MDG5: A Qualitative Analysis of the Working Environment of Skilled Birth Attendants in Cambodia	The working environment of skilled birth attendants (SBAs) in one region in Cambodia and the factors affecting their motivation and performance were explored.	A descriptive qualitative design was used with focus group discussions. Participants consisted of skilled birth attendants (SBAs) in 2 health centres and 3 referral hospitals in 1 province. Data were thematically analysed. SBAs consisted of eight primary midwives, 13 secondary midwives, one primary nurse-midwife, and three doctors with midwifery skills participated.	Policies are to be implemented that will address sufficient employee payment and performance management in order to progress toward the UN 2015 MDG5 target for maternal health.	One of the challenges to providing quality maternity care was vital access to medical supplies and lack of working equipment. Due to a heavy workload that includes having to do administrative duties, SBAs reported to not always have time or energy to clean, thus increasing susceptibility to infection from poor hygiene. Although financial incentives were explored in the study, it was noted that participants were also motivated by non-monetary reasons such as recognition, positive reinforcement and supportive supervision from management. Midwives in the study were also despondent by not being listened to during decision-making processes and a lack of opportunities to further their education and training.
13	Mansoor, G.F., Hashemy, P., Gohar, F., Wood, M. E., Ayoubi, S. F. & Todd, C. S. (2013)	This study looked at the retention rate of community midwifery education (CME) graduate in public sector health care in Afghanistan	3 quantitative instruments were used: a facility checklist assessed staffing and service volume. 2 separate questionnaires were used for midwives and facility managers,		Findings that are similar from other studies include reasons for leaving (increased workload without financial compensation) and reasons to remain (job security, fulfilling obligations to the community, providing help to underserved areas, receiving respect from the community and fulfilling deployment obligations). Retention of

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	Place: Middle East, Afghanistan Midwifery retention and coverage and impact on service utilisation in Afghanistan	and related factors.	measuring employment duration and perceived barriers to midwife retention.		midwives may be enhanced by “improved financial compensation, continuing education or professional development opportunities, and schools for children.”
14	Versaevel, N (2011) Place: Canada, Ontario Why Do Midwives Stay? A Descriptive Study of Retention in Ontario Midwives	This research evaluated the retention of midwives by investigating reasons that they stay, as well as why they leave.	A web-based survey was used to collect both qualitative and quantitative data from midwives of which 175 participants responded.	Policies and retention strategies are to integrate individual midwives, practice groups and midwifery organisations.	Quantitative analysis: Midwives experience job satisfaction related to making a difference, working autonomously and interaction with women in their care. They are also proud to be midwives and feel privileged to attend births, whilst conveying a commitment to their clients. Partners, work colleagues and family are sources of support to continue practising. Few reported that the knowledge of impending retirement was a means of coping with work-related stress. Qualitative results: Practical, relational and philosophical aspects of practice were identified and discussed. Physical issues were related to physical, emotional or financial reasons. Relational aspects referred to relationships with clients and colleagues in both a positive and negative light. It was reported that improving relationships with other members of the health care team would enhance retention of midwives. Philosophical aspects discussed the passion midwives have towards the care they provide and the associated effect it has on their clients.
15	Pugh, J. D., Twigg, D. E. & Rai, T (2013) Place: Australia	Attrition rates of midwives in maternity services in Australia is a concern. Factors	A descriptive, cross-sectional survey with a questionnaire was used where descriptive statistical analyses and content	There are implications to conduct research at the unit and institutional level in order to determine factors	Main reasons for intention to move jobs and/or leave midwifery: family commitments, working conditions and dissatisfaction with their role. Of the midwives 55-plus years old, 24% mentioned retirement as a reason for moving jobs.

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	Western Australia facing critical losses in its midwifery workforce: A survey of midwives ' intentions	relating to the intention of the midwives to move jobs and/or leave the profession were discussed.	analysis was done 712 questionnaires were returned (44.5% response rate), representing 21% of registered midwives; 69% public sector employees and 75.6% metropolitan-based.	related to the retention of midwives and how these factors the affect quality of care and health of the midwives.	Addressing certain challenges would assist with the retention of midwives, these include: rigid work arrangements inadequate remuneration, poor staffing and perceived unrealistic levels of caseload, negative workplace culture, a lack of professional development opportunities and models of care that diminished professional autonomy
16	Curtis, P., Ball, L., & Kirkham, M (2002) Place: Europe, United Kingdom Why do midwives leave? (Not) being the WM of midwife you want to be	This study explored the reasons why midwives had left the profession.	A grounded theory approach was used. 28 interviews were carried out and findings enabled the development of a questionnaire sent out to midwives who had not sent the Notification of Intention to Practise form at the end of December 2000.	Five related articles discussed issues such as "management and morale; divisions within the midwifery workforce; bullying and horizontal violence; family-friendly working practices and working life after midwifery".	Organisational factors that influenced the way participants worked included staff shortages which lead to workplace stress. Associated factors included" social support at work and limited authority to take decisions". Majority of midwives who left conveyed "that a lack of management support was a key factor in their decision to leave".

Summary of scoping review findings:

Key findings identified:	Author that described findings as motivating	Author that described findings as challenging
Inadequate nurse to patient ratios, inadequate staffing/ staff shortages		(Holland et al., 2018; Hildingsson & Fenwick, 2015; Pugh et al., 2013; Curtis et al. 2006)
Personal family commitments		(Pugh et al., 2013)
High workload / caseload		(Holland et al., 2018; Pugh et al., 2013)
Occupational burnout		(D K Creedy et al., 2017)
Administrative work		(Holland et al., 2018; Ith, Dawson & Homer, 2012)
Opportunities for permanent positions		(Holland et al., 2018)
Job security		(Holland et al., 2018

Key findings identified:	**Author that described findings as motivating**	**Author that described findings as challenging**
Relationships with the community		(Wurie et al., 2016)
Relationships with clients/ women	(Hildingsson & Fenwick, 2015; Sullivan et al., 2011; Versaevel, 2011)	
Relationships with colleagues	(Sullivan et al., 2011)	
Relationships with other professional members of the healthcare team		(Crowther et al., 2018; Versaevel, 2011)
Working conditions in general	(Wurie et al., 2016)	(Holland et al., 2018; Wurie et al., 2016; Pugh et al., 2013) This was contradicted by Blaauw et al. (2013)
Working conditions: lack of medical supplies and well maintained equipment		(Bonenberger et al., 2014; Adegoke et al., 2015; Ith, Dawson & Homer 2012)
Working conditions: negative workplace culture		(Pugh et al., 2013)
Career progression/ advancement opportunities	(Adegoke et al., 2015; Bonenberger et al., 2014)	(Wurie et al., 2016; Takase et al., 2016; Adegoke et al., 2015)
Being a part of decision-making processes		(Holland et al., 2018; Ith, Dawson & Homer, 2012)
Lack of team debriefing		(Holland et al., 2018)
Fear of litigations		(Hood et al., 2010)
Putting on a false façade for clients		(Holland et al., 2018)
Working autonomously	(Hildingsson & Fenwick, 2015; Versaevel, 2011)	(Creedy et al., 2017; Pugh et al., 2013)
Financial incentives and benefits	(Wurie et al., 2016)	(Bonenberger et al., 2014; Mansoor et al., 2013; Pugh et al., 2013; Sullivan et al., 2011; Wurie et al., 2016)
Supportive management and supervision	(Ith, Dawson & Homer, 2012)	(Curtis et al., 2006; Hood et al., 2010; Wurie et al., 2016)
Training opportunities	(Adegoke et al., 2015; Wurie et al., 2016)	(Adegoke et al,. 2015; Bonenberger et al., 2014; Ith, Dawson & Homer, 2012; Pugh et al., 2013; Wurie et al., 2016)
Being effective in their role	(Wurie et al., 2016)	

Key findings identified:	Author that described findings as motivating	Author that described findings as challenging
Community service/ commitment	(Mansoor et al., 2013; Wurie et al., 2016)	
Making a difference	(Versaevel, 2011)	
Job satisfaction in general	(Sullivan et al., 2011)	
Mentorship of younger midwives	(Adegoke et al., 2015; Hildingsson & Fenwick, 2015)	
Attending births	(Sullivan et al., 2011)	
Recognition and respect from community, colleagues and management	(Bonenberger et al., 2014; Ith, Dawson & Homer, 2012; Mansoor et al., 2013)	
Professional pride	(Sullivan et al., 2011)	

Full-text articles excluded:

Nr	Author / Date / Title	Theoretical conceptual framework / Reason for exclusion from scoping review
1	George, G., Quinlan, T., Reardon, C. & Aguilera. J.F (2012) Where are we short and who are we short of? A review of the human resources in South Africa	The article was excluded as it focuses on determining workforce shortages and not motivating factors, workplace challenges nor retention strategies.
2	Chimwaza, W., Chipeta, E., Ngwira, A., Kamwendo, F., Taulo, F. & Bradley, S (2014) What makes staff consider leaving the health service in Malawi?	The study was excluded as it focused on mid-level providers (MLPs) who do not have the same scope of practice nor work expectations as midwives.
3	Mcauliffe, E., Daly, M., Kamwendo, F., Masanja, H., Sidat, M. & De Pinho, H. (2013) The Critical Role of Supervision in Retaining Staff in Obstetric Services: A Three-Country Study	The study was excluded as it focused on mid-level providers (MLPs) who do not have the same scope of practice nor work expectations as midwives.
4	Belaid, L., Dagenais, C., Moha, M. & Ridde, V.(2017) Understanding the factors affecting the attraction and retention of health professionals in rural and remote areas: A mixed-method study in Niger	This study was excluded as participants included health professionals, however, did not specify how many midwives were consulted. The study also focused on midwifery students intentions to work in rural areas, as opposed to retention of already qualified and experienced midwives.
5	Brooks, B. & Anderson, M (2004) Defining Quality of Nursing Work-life	This article was excluded as it focussed on the development of a tool to measure Quality of Nursing Worklife (QNWL). The tool has been developed for nurses and current South African

		midwifery training is accompanied by registered nurse training. The tool has been used as part of the methodology to obtain data as it has been used to meet the second research objective of this study.
6	Chani, K., Cassim, N. & Karodia, A. M (2014) An investigation of staff turnover at a private healthcare provider in the Kavango region, Namibia	This study was excluded as participants included health providers. However it was not specified how many midwives were included, instead, it appears they were sampled together with general nurses who have a different scope of practice. This study also focussed on the private sector, as opposed to the public sector setting chosen for the study.
7	Dubois, C. A. & Singh, D (2009) From staff-mix to skill-mix and beyond: towards a systemic approach to health workforce management	This article was excluded as it focusses on enhancing the available workforce by focussing on the optimum number of staff and skill mix required to render efficient quality patient care. It does not mention motivating factors or challenges experienced by midwives.
8	George, C. (2015) Retaining professional workers: What makes them stay?	The purpose of this paper was to investigate why professional workers remain in their organisations. This article was excluded as midwives were referred to in the literature of the article, however, does not indicate that participants were midwives and rather consisted of professions that included Accountants, IT professionals, Consultants, Marketing and Sales Professionals and HR professionals.
9	George, G., Atujuna, M. & Gow, J (2013) Migration of South African health workers: the extent to which financial considerations influence internal flows and external movements	This article was excluded as, despite midwives being referred to once in the literature of the article, it does not indicate how many participants were midwives. Instead, they have been grouped together with all health care workers and is thus does not meet the criteria of the scoping review.
10	Mcauliffe, E., Daly, M., Kamwendo, F., Masanja, H., Sidat, M. & De Pinho, H (2013) The Critical Role of Supervision in Retaining Staff in Obstetric Services: A Three-Country Study	The study was excluded as it focused on mid-level cadres. Nurse midwives were included, however, they formed a very small percentage of the sample from whom data was collected. Majority of participants consisted of enrolled nurses who do not have the same scope of practice nor work expectations as midwives.
11	Ntuli, S. T. & Ogunbanjo, G. A (2014) Midwifery workforce profile in Limpopo Province referral hospitals	The study was excluded as it examined the profile of registered nurses involved in maternity care and did not address the objective of the scoping review.
12	Scott, A., Witt, J. & Duffield, C. (2015) What do nurses and midwives value about their jobs? Results from a discrete choice experiment	Findings from this article focused on how nurses and midwives value different work-related attributes if they were presented with the option to choose these attributes. It does not specifically explore motivating factors nor challenges they face at work
13	Skinner, N., Van Dijk, P., Elton, J. & Auer, J. (2011) An in-depth study of Australian nurses ' and midwives ' work-life interaction	The following aspects of sampling were considered when excluding this article from the scoping review: Participants of the first study mentioned were primarily nurses and not midwives, of which two were included. The second study in the article grouped the nursing and midwifery participants together and did not state how many were midwives. The second study's participants were also sampled from regional hospitals. These participants do not have the same scope of practice or work expectations as midwives in primary public sectors.
14	Tanaka, N., Horiuchi, S., Shimpuku, Y. & Leshabari, S (2015) Career development expectations and challenges of midwives in Urban Tanzania: a preliminary study	This study describes the professional desires of midwives in Tanzania. Categories identified were related to learning and development instead of motivating factors or challenges experienced by midwives, thus was excluded from the scoping review.
15	Tshitangano, T. G. (2013)	This study refers to workplace factors that contribute to nurses leaving their jobs, however, it

	Factors that contribute to public sector nurses' turnover in Limpopo province of South Africa	was noted that registered professional nurses formed part of the sample and no specification was made to midwives or staff working in maternity care settings.
16	Warmelink, J. C., Wiegers, T. A., de Cock, T. P., Spelten, E. R. Hutton, E. K (2015) Career plans of primary care midwives in the Netherlands and their intentions to leave the current job	It was noted that job satisfaction and the age group between 30 and 45 years had an influence on midwives intention to leave their current jobs. However, this study did not explore motivating factors or challenges associated with job satisfaction, which in turn is associated with retention of staff.

Annexure 2: Information sheet for participants

Information sheet for participation

Study title: Factors influencing retention of midwives in maternity services of the public sector in Johannesburg

Dear Participant,

I, Won-li Richardson, am currently a Master's student at the University of Witwatersrand in Johannesburg. The research is to be conducted under the supervision of Mrs Barbara Hanrahan of the Department of Nursing at the University of Witwatersrand.

I would like to invite you to take part in this research and will require your consent to participate. Your participation in this research would be greatly appreciated.

Your role in this research will be to provide answers during an in-depth interview and self-administered questionnaire. With your consent, these interviews are to be audio recorded and will not be used to assess, nor evaluate your academic or clinical knowledge. The approximate time for the interview would be no longer than 30 minutes and will take place at a venue that is convenient for you. The estimated time to complete the questionnaire is 20 minutes and will be collected in a method ensuring anonymity. You will be required to sign consent forms for the interview beforehand, whilst completion of the self-administered questionnaire would serve as consent for participation in the study.

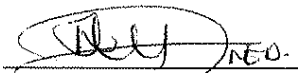
The information provided will be analysed anonymously along with other participants' information and may be quoted in the research report with no name or institution. Your information will be kept confidential within the research team and associated parties involved in this study. There may be indirect benefits of your participation that will aid in the research towards enhancing midwifery workplace. Please note that there is no remuneration for participating in this research. Participation in this study is completely voluntary and refusal to take part or withdrawal from the study at any given time will not result in any consequences of a negative nature. Findings from the study may be published at a later stage.

Approval to conduct this study has been provided by the University of Witwatersrand, in accordance with its ethics review and approval procedures, ethics clearance certificate no. M170503. Approval has also been obtained from the Johannesburg Health District Research Committee, NHRD:GP_2017RP18_135.

For any further information please feel free to contact myself (Joanna.wlu@gmail.com / 011 812 3965 / 083 760 8196) or Professor Cleaton-Jones: Witwatersrand University Ethics committee (011 717 2301)

Kind regards

Won-li Richardson



Annexure 3: Self-Administered Questionnaire

Brooks' Quality of Nursing Work-life Survey (BQNW) (Brook & Anderson, 2005)

Brooks' Quality of Nursing Work Life Survey

This survey contains statements about nursing work life. Please indicate how much you disagree or agree with each statement using the scale given below. If you are unsure about your answer to a given item, think about it for a minute and then respond. Please mark you answer by circling one number. There are no right or wrong answers.

	Strongly Disagree					Strong Agree
1. I receive a sufficient amount of assistance from unlicensed support personnel (the dietary aides, housekeeping, patient care technicians, and nursing assistants).	1	2	3	4	5	6
2. I am satisfied with my job.	1	2	3	4	5	6
3. My workload is too heavy.	1	2	3	4	5	6
4. In general, society has an accurate image of nurses.	1	2	3	4	5	6
5. I am able to balance work with my family needs.	1	2	3	4	5	6
6. I have the autonomy to make patient care decisions.	1	2	3	4	5	6
7. I am able to communicate well with my nurse manager/supervisor.	1	2	3	4	5	6
8. I have adequate patient care supplies and equipment.	1	2	3	4	5	6
9. My nurse manager/supervisor provides adequate supervision.	1	2	3	4	5	6
10. It is important for a hospital to offer employees on-site childcare services.	1	2	3	4	5	6
11. I perform many non-nursing tasks.	1	2	3	4	5	6
12. I have energy left after work.	1	2	3	4	5	6
13. Friendships with my co-workers are important to me.	1	2	3	4	5	6
14. My work setting provides career advancement opportunities.	1	2	3	4	5	6
15. There is teamwork in my work setting.	1	2	3	4	5	6
16. I experience many interruptions in my daily work routine.	1	2	3	4	5	6
17. I have enough time to do my job well.	1	2	3	4	5	6
18. There are enough RNs in my work setting.	1	2	3	4	5	6
19. I feel a sense of belonging in my workplace.	1	2	3	4	5	6
20. Rotating schedules negatively affect my life.	1	2	3	4	5	6
21. I am able to communicate with the other therapists (physical, respiratory, etc.).	1	2	3	4	5	6
22. I receive feedback on my performance from my nurse manager/supervisor.	1	2	3	4	5	6
23. I am able to provide good quality patient care.	1	2	3	4	5	6
24. My salary is adequate for my job given the current job market conditions.	1	2	3	4	5	6
25. My organization's policy for family-leave time is adequate.	1	2	3	4	5	6
26. I am able to participate in decisions made by my nurse manager/supervisor.	1	2	3	4	5	6
27. It is important for a hospital to offer employees on-site day care for elderly parents.	1	2	3	4	5	6
28. I feel respected by physicians in my work setting.	1	2	3	4	5	6
29. It is important to have a designated, private break area for the nursing staff.	1	2	3	4	5	6
30. It is important to me to have nursing degree-granting programs available at my hospital.	1	2	3	4	5	6
31. I receive support to attend inservices and continuing education programs.	1	2	3	4	5	6
32. I communicate well with the physicians in my work setting.	1	2	3	4	5	6
33. I am recognized for my accomplishments by my nurse manager/supervisor	1	2	3	4	5	6
34. Nursing policies and procedures facilitate my work.	1	2	3	4	5	6

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	Strongly Disagree					Strongly Agree
35. The security department provides a secure environment.	1	2	3	4	5	6
36. It is important for a hospital to offer employees on-site ill child care services.	1	2	3	4	5	6
37. I would be able to find my same job in another organization with about the same salary and benefits.	1	2	3	4	5	6
38. I feel safe from personal harm (physical, emotional, or verbal) at work.	1	2	3	4	5	6
39. I believe my job is secure.	1	2	3	4	5	6
40. Upper-level management has respect for nursing.	1	2	3	4	5	6
41. My work impacts the lives of patients/families.	1	2	3	4	5	6
42. I receive quality assistance from unlicensed support personnel (the dietary aides, housekeeping, patient care technicians, and nursing assistants).	1	2	3	4	5	6

DEMOGRAPHIC INFORMATION

Please mark only one answer for each question unless otherwise indicated.

1. What is your HIGHEST earned diploma or degree in **nursing**?

Diploma
Associate degree
BSN
Master's degree
Doctoral degree
Other (specify)_____

2. Are you: Male or Female

3. What year were you born? _____

4. What is your marital status?
Married (First marriage)
Married (Not first marriage)
Widowed
Divorced
Separated
Never Married

5. Indicate the number of dependent children you have living **at home** in each of the following age ranges.

0 - 2 Years of Age	0	1	2	3	4 or More
3 - 4 Years of Age	0	1	2	3	4 or More
5 Years of Age	0	1	2	3	4 or More
6 - 12 Years of Age	0	1	2	3	4 or More
13 - 18 Years of Age	0	1	2	3	4 or More
Over 18 Years of Age	0	1	2	3	4 or More

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6. Are you responsible for the care of your (and/or your spouse/partner's) elderly parents?
   No
   Yes

   If yes, describe the type of care you provide. _____
   _____
   _____

7. What is your Racial/Ethnic Background?

   African-American
   American Indian or Alaskan Native
   Asian
   Mexican-American
   Pacific Islander
   Puerto Rican
   Other Hispanic
   White non-Hispanic
   Other (specify)_____

8. For your current PRINCIPAL nursing position, do you work:

   Full-Time (Work an entire calendar year on a full-time basis.)
   Part-Time (Work an entire calendar year on a part-time basis.)

9. Do you rotate shifts?
   No
   Yes

10. Is rotating shifts
    Voluntary or Mandatory?

11. Do you receive additional compensation for rotating shifts?
    No
    Yes

12. Identify the type of unit where you currently work in your PRINCIPAL nursing position.
    Critical Care
    Emergency Room
    Geriatrics
    Home Care
    Long-term Care
    Neonatal Intensive Care
    Medical-Surgical
    Obstetrics
    Oncology/Hematology
    Operating Room/Recovery Room
    Orthopedics
    Out-patient Clinic/Surgery

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Pediatrics
Psychiatry
Rehabilitation
Sub-Acute Care
Telemetry
Other (specify)_____

13. Are certified in your specialty area?
    No
    Yes
    If yes, what is your specialty certification? _____

14. Do you receive additional compensation for being certified?
    No
    Yes

15. Current PRINCIPAL nursing position (mark only one answer).
    Staff Nurse
    Team Leader
    Charge Nurse
    Unit Manager

16. Do you receive additional compensation for being the charge nurse?
    No
    Yes

COMMENTS:

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Annexure 4: Consent to participate in in-depth interview

Consent to participate in the study:

Study title:

Factors influencing retention of midwives in maternity services of the public sector in Johannesburg.

I,_____, have read through the information sheet accompanying this consent form and have been provided the opportunity to question any aspects that may have been uncertain. I hereby understand what is being requested of me and as such voluntary consent to be a participant during an in-depth interview for this study. I understand that all the information I provide will be confidential and that I have the right to withdraw from the study at any time.

Print Name of Participant_____

Signature of Participant _____

Date _____

Day/month/year

Annexure 5: Consent for audio recording for interviews

Consent for audio recording:

Study title:

Factors influencing retention of midwives in maternity services of the public sector in Johannesburg.

I,_____, have read through the information sheet accompanying this consent form and have been provided the opportunity to question any aspects that may have been uncertain. I hereby understand what is being requested of me and as such voluntarily consent to be a participant and be audio recorded during an interview for this study. I understand that all the information I provide will be confidential and that I have the right to withdraw from the study at any time.

Print Name of Participant _____

Signature of Participant _____

Date _____

Day/month/year

Annexure 6: In-depth interview guide

Questions

1. Please tell me what motivates you to stay in the field and practising as a midwife?

2. Please tell me what the workplace challenges you experience are?

3. Please describe how you have overcome these workplace challenges?

4. Please describe the kind of support would you like to have in your workplace?

5. Please identify the one most definite critical work-related factor that would make you leave midwifery?

6. Is there anything else you would like to tell me?

Annexure 7: In-depth interview coded transcription

PARTICIPANT 7 (Labour/Postnatal): Worked>10years	Concepts
***Participant appeared relaxed throughout the interview. The interview took place at a time when the ward was quiet and there were no interruptions.**	
Interviewer: Thank you very much for participating in my study, Sister. I would just like to confirm that you have signed my consent for the interview as well as the audio recording thereof?	
Participant: Okay, thank you.	
Interviewer: All right. My first question is, I would like to please know what motivates you to stay in the midwifery field and practising as a midwife?	
Participant: I stay in midwifery for more than 10 years because I now I came here being doubtful not knowing what I am going to see, the challenge and whatever, but at the end of the day I have enjoyed with the unit because giving a mother a baby is a wonderful thing to see – the family being happy to receive a newborn baby.	**Satisfaction with assisting during birth of healthy baby to mother – Internal satisfaction**
Interviewer: Is there any other reason that you enjoy practising as a midwife?	
Participant: Very much because at some point you learn that with midwifery it is not one delivery, sometimes it is looking at why there is slow progress, not ending, not having the baby on you and then finding that the baby should be delivered with by the doctors at the hospital. Not for your midwife to deliver. At some point, you find now you don't have to cross the line for the baby to be born.	
Interviewer: All right. Good, thank you. Could you please tell me what are the workplace challenges that you experience?	
Participant: The challenges we have is not having the resources. That is a big issue.	**Equipment and Material resources**
Interviewer: What types of resources are you referring to?	
Participant: Probably, maybe having the resources that we can use on a patient. Others might be there but you find out that they are old and need to be repaired and so forth. And again, there are challenges we have is for families when they bring the patient when you explain to them that patient was supposed to be in the hospital, they find that the hospital and clinic are the same why should they run around with the patient. Sometimes that lack of knowledge to our families and we need to come down and explain to them that, no patient we will see and then we will call the ambulance. They usually think that the clinic is the getaway for the patient to the hospitals and sometimes we find we have a challenge with the ambulances.	**Community and patient family conflict/problems** **EMS / Ambulance delays**
Interviewer: Was that another challenge for you?	
Participant: Ja.	

Interviewer: All right.	
Participant: But now it is much, much better not like before. Sometimes we do experience those things and there is a delay but it is much better now than before where you find that you start with a patient maybe complicating and so forth.	**EMS / Ambulance delays**
Interviewer: Any other workplace challenges that you experience?	
Participant: Shortage of staff.	
Interviewer: How does that influence you?	**Staff shortages**
Participant: I would say the influence of shortage of staff, for example, you find that if you are two or three on a shift if the other one is getting ill I would do the example of the week before last week. I for one, I find that there was a strike in that case and we were two in a shift, the other midwives had to struggle because they can't run the unit alone and then they had to take the midwives to another institution for her to work. So that is a challenge that we are having which we can run away because they are always taking us, there is always a shortage of staff, everywhere anyway, ja.	
Interviewer: Any other challenges that you have experienced.	**Unbooked patients**
Participant: Spoken about the family and the patient that are not booking, you know, is a challenge because getting a patient that is not booked in the labour ward is quite strenuous because you have to do the ante-natal booking and everything before you can deliver the baby. Getting the bloods and all those things. It is a challenge and you know in labour ward, again, is this thing of HIV we have to dig with the patient and we find she cannot even give the truth about her status and whatever, that is a challenge we have.	**Lack or no antenatal blood work/ workup**
Interviewer: Anything else?	
Participant: I would say, for now that is what is what I am thinking of.	
Interviewer: So there's many challenges you mentioned for me. Can you tell me how do you try to overcome those workplace challenges?	
Participant: Really, if I want to tell you the truth - we are working because we are supposed, if I am here, I need to give service delivery for whatever I might be having a challenge I may have. At the end of the day I have to make sure that the patient at least got service delivery. Nothing to think of – this is a challenge I can't do – if the patient come in, not booked I have to do something for the patient so that at the end of the day she gets the service delivery and then with the equipment that we do not have we have to improvise somehow so that is a challenge.	**Equipment and material resources**
Interviewer: Can you give me an example? How do you improvise?	
• **End of example from participant transcription**	

Annexure 8 : Permission letter to use survey questionnaire

Won-li Richardson
24 Farrarmere Country Estates
Farrarmere
Benoni, South Africa
1501

04 May 2017

Attention: President - The Brooks Group, LLC (Chicago)

Dear Dr Beth A. Brooks

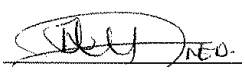
Re: Request permission to use Quality of Nursing Work-life Survey

I, Won-li Richardson, am currently a Master's student at the University of Witwatersrand in Johannesburg, South Africa. The research I wish to conduct is entitled: Factors influencing retention of midwives in maternity services of the public sector in Johannesburg. This research will comprise of a mixed method study, explorative in nature and is to be conducted under the supervision of Mrs Barbara Hanrahan of the Department of Nursing at the University of Witwatersrand.

As it would be a mixed methodology design, in-depth interviews would be used to describe the factors that influence midwives decisions to remain practising in Midwives Obstetric Units (MOUs), as well as workplace challenges that midwives face in MOUs. Simultaneously, a self-administered questionnaire would be used to assess the quality of work-life rated by midwives

I hereby kindly request permission for the **Quality of Nursing Work-life Survey** to be used to collect data for the quantitative section of the research, as it will address the objectives I have set to meet my research aim. Your permission is this regard would be greatly appreciated. For any further information please feel free to contact myself (Joanna.wlu@gmail.com / +2711 812 3965 / +2783 760 8196) or Professor Cleaton-Jones: Witwatersrand University Ethics committee (+2711 717 2301)

Kind regards
Won-li Richardson (Jo-anna)



9217 West Thorndale Avenue • Chicago, Illinois USA 60646
tel 773-612-7224 • bbrooks@rogers.net

June 15, 2017

Ms. Won-li Richardson
24 Farrarmere Country Estates
Farrarmere
Benoni, South Africa
1501

Dear Ms. Richardson:

You have permission to use my instrument, Brooks' Quality of Nursing Worklife Survey© (BQNW) in your Master's research at the University of Witwatersrand in Johannesburg, South Africa entitled: Factors influencing retention of midwives in maternity services of the public sector in Johannesburg. I understand your research study will explore the quality of nursing worklife rated by midwives

In return, I require that you:

- Report summary findings to me from the survey, including reliability analysis
- Credit the use and my authorship of the survey in any publication of your research

Keep in mind that the survey was originally designed to assess the nursing worklife of staff nurses in hospital settings. Using the survey with other groups of nurses (e.g. charge nurses, nurse managers, etc.) will require modification of some survey items. Making significant changes to the intent of the item and/or adding items is prohibited. However, items may need slight modifications based cultural differences. Please notify me of such changes.

Please don't hesitate to call upon me to discuss your research. I am also available for speaking presentations or consultation.

Good luck with your research.

Sincerely,

Beth A. Brooks

Beth A. Brooks, PhD, RN, FACHE
President

4217 West Thorndale Avenue • Chicago, Illinois USA 60646
www.773-612-7224 • thebrooksgroupllc.net

Item Key To Factor Analysis-Derived Subscales (BQNW)

Subscale #1, Homelife/Worklife
The work life/home life dimension is defined as the interface between the nurses' work and home life.
Items 5, 10, 12, 20, 25, 27, 36. Item #20 is reversed scored.

Subscale #2, Work Design
The work design dimension is the composition of nursing work and describes the actual work nurses perform.
Items 1, 2, 3, 6, 11, 16, 17, 18, 23, 42

Subscale #3, Work Context
The work context dimension includes the practice settings in which nurses' work and explores the impact of the work environment on both nurse and patient systems.
Items 7, 8, 9, 13, 14, 15, 19, 21, 22, 26, 28, 29, 30, 31, 32, 33, 34, 35, 38, 40

Subscale #4, Work World
The work world dimension is defined as the effects of broad societal influences and change on the practice of nursing.
Items 4, 24, 37, 39, 41

Beth A. Brooks, Ph.D., R.N., FACHE
President
The Brooks Group, LLC

4217 WEST THORNDALE AVENUE • CHICAGO, ILLINOIS USA 60646
voice 773-583-7224 • thebrooksgroupllc.net

Interpreting Scores for Brooks' Quality of Nursing Worklife Survey©

Total Score
Range 42-252
42-112 = low QNWL
113-182 = moderate QNWL
183-252 = high QNWL

Worklife-Homelife Sub-scale
Range 7-42
Low 7-18
Moderate 19-29
High 30-42

Work Design Sub-scale
Range 10-60
Low 10-26
Moderate 27-44
High 45-60

Work Context Sub-scale
Range 20-120
Low 20-38
Moderate 39-77
High 78-120

Work World Sub-scale
Range 5-30
Low 5-12
Moderate 13-20
High 21-30

Beth A. Brooks, Ph.D., R.N., FACHE
President
The Brooks Group, LLC

Richardson,Jo-Anna

From: Jo-anna Richardson <joanna.wlu@gmail.com>
Sent: 04 June 2019 03:37 PM
To: Richardson,Jo-Anna
Subject: Fwd: Request to use QNWL survey

---------- Forwarded message ---------
From: **Beth A Brooks** <bethbrooks@thebrooksgroupllc.net>
Date: Wed, 29 Nov 2017, 18:24
Subject: Re: Request to use QNWL survey
To: Jo-anna Richardson <joanna.wlu@gmail.com>
Cc: Barbara Hanrahan <barbara.hanrahan@wits.ac.za>

Hello Jo-anna. I have read your letter and the changes you are proposing. My major concern is that my survey tool was designed for staff RNs working in hospital settings. The qualitative research and extensive lit review I completed to design the survey is based on this research. As such the survey measures worklife for RNs in hospitals settings. Changing the intent of items as you have and eliminating other items that "don't apply" in your setting will (I suspect) impact the validity of the survey. What if the changes you are proposing creates a different construct (or concept)? How do you know you are measuring quality of nurse midwife quality…or are you now measuring something else?

So in other words, if you were to conduct qualitative research of the midwives working in your settings, as well as conduct a literature review specific to the work life of midwives you may find very different issues of concern to the work life quality of midwives. Certainly there will be similar work life concerns between midwives and staff RNs, but the two roles (at least in the USA) are very different, as are the work settings, scope of practice, and the like. For these reasons I am reluctant to approve your changes.

I'm sure this is not the answer you hoped to receive, but on the surface the changes you are suggesting may seem superficial. However, from a measurement perspective you probably are suggesting changes related to the validity of the construct. Stated more simply--quality of nursing worklife and quality of nurse midwife worklife may be two entirely different concepts, with different issues that impact the worklife of these two different types of nurses.

You might speak with your academic advisor about a more rigorous, scholarly approach to modifying my instrument for use with nurse midwives. We could work jointly on such a project guiding you through the process I used to create my survey, but you would be the author on a new survey tool designed explicitly for nurse midwives. Perhaps we can arrange a facetime or Skype phone call to discuss further if you so desire.

Kind regards, Dr. Beth Brooks

Beth A. Brooks, PhD, RN, FACHE
Robert Wood Johnson Foundation Executive Nurse Fellow Alumnus, 2012 Cohort

Annexure 9: Approval of title by Postgraduate Assessors

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

14 August 2017
Person No: 1440761
PAG

Ms W Richardson
Postnet Suite 25
Private Bag X01
Farrarmere
1518
South Africa

Dear Ms Richardson

Master of Science in Nursing: Approval of Title

We have pleasure in advising that your proposal entitled *Factors influencing retention of midwives in maternity services of the public sector in Johannesburg* 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 10: HREC (Medical) Ethics Approval

R14/49 Mrs Won-li Richardson

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M170503

NAME: (Principal Investigator)	Mrs Won-li Richardson
DEPARTMENT:	Nursing Education Johannesburg Health District
PROJECT TITLE:	Factors Influencing Retention of Midwives in Maternity Services of the Public Sector in Johannesburg
DATE CONSIDERED:	26/05/2017
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Mrs Barbara Hanrahan
APPROVED BY:	Prof P Cleaton-Jones, Chairperson, HREC (Medical)
DATE OF APPROVAL:	22/09/2017

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary in Room 301, Third floor, Faculty of Health Sciences, Phillip Tobias Building, 29 Princess of Wales Terrace, Parktown, 2193, University of the Witwatersrand. 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 resubmit the application to the Committee. **I agree to submit a yearly progress report**. The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. In this case, the study was initially reviewed in May and will therefore be due in the month of May each year. Unreported changes to the application may invalidate the clearance given by the HREC (Medical).

Principal Investigator Signature

19/12/2017

Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

Annexure 11: Request letter to the Gauteng Department of Health, for permission to conduct this study.

Won-li Richardson
24 Farrarmere Country Estates
Farrarmere
1501

10 May 2017

Pixley Ka Isaka Seme Street
Marshall Town
Johannesburg
2001

Attention: Gauteng Department of Health

Dear Sir/Madam

Re: Request to conduct a study

I, Won-li Richardson, am currently a Master's student at the University of Witwatersrand in Johannesburg. The research I wish to conduct is entitled: Factors influencing retention of midwives in maternity services of the public sector in Johannesburg. This research will comprise of a mixed method study, explorative in nature and is to be conducted under the supervision of Mrs Barbara Hanrahan of the Department of Nursing at the University of Witwatersrand.
I hereby kindly request permission for my study to be conducted in your region with midwives working in maternity units forming part of the sample group.

Their participation in this study would be greatly appreciated and involves their role of providing truthful answers during individual in-depth interviews and self-administered questionnaires. Participant information and consent forms for these interviews, as well as the audio recordings thereof, will be provided. The approximate time for each interview to take place is intended to be no longer than 30 minutes and will take place at a venue that is convenient for the participant. The estimated time to complete that questionnaire is 20 minutes and will be collected in a method ensuring anonymity.

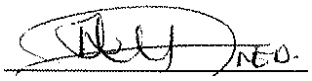
The information provided will be analysed anonymously along with other participants' information and will be kept confidential within the research team and associated parties involved in this study.

Participants will be informed that there no remuneration will be granted for participation in this study and that participation in this study is completely voluntary. Refusal to take part or withdrawal from the study at any given time will not result in any consequences of a negative nature. There may be indirect benefits of their participation that will aid in the research towards enhancing midwifery workplace.

For any further information please feel free to contact myself (Joanna.wlu@gmail.com / 011 812 3965 / 083 760 8196) or my supervisor, Mrs Barbara Hanrahan (011 488 4275 / Barbara.Hanrahan@wits.ac.za)

Kind regards

Won-li Richardson



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JOHANNESBURG HEALTH DISTRICT

Enquiries: Dr EM Ohaju
Tel: +27(0) 11 694 3888
Cell: 082 731 6672 / 076 8831659
Email: Elizabeth.Ohaju@gauteng.gov.za

Hillbrow CHC: Administration Building
Cr Smith Str. & Klein Street
Private Bag X21, Johannesburg
South Africa, 2017

The University of the Witwatersrand
Johannesburg

joanna.wlu@gmail.com

Ref: 2017-08-004

NHRD: GP_2017RP18_135

Dear: Won-li Richardson

Re*: Factors influencing retention of midwives in maternity services of the public sector in Johannesburg.*

Your application dated **2017/08/15** refers.

The District Research Committee has reviewed your application. This letter serves as an in-principle approval to access the Districts Health facilities (mentioned below) for the above project subject to following conditions:

The facility to be visited **ALEXANDRA CHC HILLBROW CHC, ITIRELENG CHC, LILLIAN NGOYI CHC, MOFOLO CHC**

The research can only commence after you submit an ethics clearance certificate from a recognized institution.

- This facility will be visited from 14/09/2017 to 14/09/2018
- You will report to the Facility Manager before initiating the study.

Region	Regional Health Manager	Contact No.	Cell phone
D	Ms Maria Mazibuko	011 674 1200	082 781 9919
ABEF	Ms L Matlala	011 440 1231	082 307 0267

- Participants' rights and confidentiality will be maintained all the time.
- No resources (Financial, material and human resources) from the above facilities will be used for the study. Neither the District nor the facility will incur any additional cost for this study.
- The study will comply with Publicly Financed Research and Development Act, 2008 (Act 51 of 2008) and its related Regulations.
- You will submit a copy (electronic and hard copy) of your final report. In addition, you will submit a six-monthly progress report to the District Research Committee.

- Your supervisor and University of South Africa will ensure that these reports are being submitted timeously to the District Research Committee.
- The District must be acknowledged in all the reports/publications generated from the research and a copy of these reports/publications must be submitted to the District Research Committee.

We reserve our right to withdraw our approval, if you breach any of the conditions mentioned above.

Please feel free to contact us, if you have any further queries. On behalf of the District Research Committee, we would like to thank you for choosing our District to conduct such an important study.

Regards,

Mrs M. Morewane
Chief Director
Johannesburg Health District
Date: 15/9/2017

Annexure 12: Request letter to MOU facility managers, for permission to conduct this study

Won-li Richardson
24 Farrarmere Country Estates
Farrarmere
1501

11 June 2018

Attention: MOU facility manager

Dear Sir/Madam

Re: Request to conduct a study

I, Won-li Richardson, am currently a Master's student at the University of Witwatersrand in Johannesburg. The research I wish to conduct is entitled: Factors influencing retention of midwives in maternity services of the public sector in Johannesburg. This research will comprise of a mixed method study, explorative in nature and is to be conducted under the supervision of Mrs Barbara Hanrahan of the Department of Nursing at the University of Witwatersrand.

I hereby kindly request permission for my study to be conducted at your clinical facilities with midwives working in maternity units forming part of the sample group.

Their participation in this study would be greatly appreciated and involves their role of providing truthful answers during individual in-depth interviews and self-administered questionnaires. Participant information and consent forms for these interviews, as well as the audio recordings thereof, will be provided. The approximate time for each interview to take place is intended to be no longer than 30 minutes and will take place at a venue that is convenient for the participant. The estimated time to complete the questionnaire is 20 minutes and will be collected in a method ensuring anonymity.

The information provided will be analysed anonymously along with other participants' information and will be kept confidential within the research team and associated parties involved in this study.

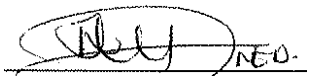
Participants will be informed that no remuneration will be granted for participation in this study and that participation in this study is completely voluntary. Refusal to take part or withdrawal from the study at any given time will not result in any consequences of a negative nature. There may be indirect benefits of their participation that will aid in the research towards enhancing midwifery workplace.

Approval to conduct this study has been provided by the University of Witwatersrand, in accordance with its ethics review and approval procedures, ethics clearance certificate no. M170503. Approval has also been obtained from the Johannesburg Health District Research Committee, NHRD:GP_2017RP18_135.

For any further information please feel free to contact myself (Joanna.wlu@gmail.com / 011 812 3965 / 083 760 8196) or my supervisor, Mrs Barbara Hanrahan (011 488 4275 / Barbara.Hanrahan@wits.ac.za)

Kind regards

Won-li Richardson



Annexure 13: Confirmation of language editing

LANGUAGE INK

Jansie Matthee
Language practitioner
Translation, text editing, proof reading, project management, copy writing, document design
083 461 8175 jansie.matthee@gmail.com 021 911 3763
19 Wessel Street, Parow, 7500

08.03.2019

Confirmation of language editing

I, Jansie Matthee, professional, qualified and practicing text editor, hereby confirm that the dissertation of Won-li Richardson was edited by me in preparation for submission to the Faculty of Health Sciences, University of Witwatersrand, in fulfilment of the requirements for the degree of Master of Science, in March 2019.

Title: *FACTORS INFLUENCING RETENTION OF MIDWIVES IN MATERNITY SERVICES OF THE PUBLIC SECTOR IN JOHANNESBURG*

Should you have any queries, kindly contact me on the above contact details.

Regards
Jansie Matthee