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Mathibe-Neke, Johanna Mmabojalwa

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PSYCHOSOCIAL RISK ASSESSMENT BY MIDWIVES DURING ANTENATAL CARE: A FOCUS ON PSYCHOSOCIAL SUPPORT

Johanna Mmabojalwa Mathibe-Neke

A thesis submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in fulfilment of the requirements for the degree of Doctor of Philosophy

Johannesburg, 2012

DECLARATION

I, Johanna Mmabojalwa Mathibe-Neke, declare that, *Psychosocial risk assessment by midwivesduring antenatal care: A Focus on psychosocial support* is my own work. It is being submitted for the Degree of Philosophy at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other University.

_____

Signature

Signed at:_____ on this day of_____

PRESENTATIONS AND PUBLICATIONS IN SUPPORT OF THIS THESIS

PRESENTATIONS

1. Bloemfontein, 8th Annual Congress of Midwives of South Africa, Dec 2009 (data collection and presentation)**Psychosocial risks during pregnancy: A review of the midwifery training regulations and the midwifery scope of practice in South Africa.**

2. Kenya July 2010 STTI (Sigma Theta Tau International Congress)
   The psychosocial component of midwifery education in South Africa: A time to reflect.

3. Durban, South Africa June 2011 International Congress for Midwives
   "Are midwives talking "to"or talk "with" childbearing women?"

4. Wits Therapeutic Science Research Day. August 2011.
   "Are midwives talking "to"or talk "with" childbearing women?"

PUBLICATIONS

Title: **The perceptions of midwives regarding psychosocial risk assessment and psychosocial support during antenatal care.** Submitted to the African Journal of Nursing and Midwives (AJNM)

ABSTRACT

The rationale of any national screening programme is to recognize the benefits for public health, to test a predominantly healthy population including low risk pregnant women, and to detect risk factors for morbidity in order to provide timely care interventions.

The South African health care system faces many challenges that undoubtedly impact on maternal health, resulting in poor quality of care and indirectly causing maternal deaths. The government has embarked on a number of initiatives that address women's psychosocial wellbeing during pregnancy, for example free maternity care, legalizing abortion, expanding on provider-initiated HIV counseling and testing for antenatal patients.

These initiatives imply a re-look at antenatal care screening, in order to identify wider determinants of health that may have an impact on a woman's psychosocial wellbeing. This includes amongst others, poor socio-economic conditions such as poverty, lack of social support, general health inequalities, domestic violence and a history of either personal or familial mental illness, all of which have the capacity to influence a pregnant woman's decision to utilize health care services. The intention of this study was therefore to establish the extent of psychosocial risk assessment for pregnant women during antenatal care, with a focus on the psychosocial support.Ethical clearance was obtained from the University of the Witwatersrand Human Research Ethics Committee (Protocol no. M081013).

A mixed-method approach was applied through combining quantitative and qualitative research techniques, methods and approaches to address psychosocial risk assessment and psychosocial support by midwives during antenatal care. An explanatory sequential design was used.

The methodology was aimed at accommodating the diverse population involved in the study, the nature of data being sought and the number of investigations conducted. A fully mixed research approach was implemented interactively through all the stages of the study.

The study took place in six phases to meet the purpose of this research. Phase 1 entailed quantitative data collection and analysis; phase 2 qualitative data collection and analysis; phase 3 report writing; phase 4 formulation of guidelines; phase 5 pilot test; phase 6 integration of results and findings, and writing of final report.

The philosophical basis of the study is based on the researcher's values and belief of holism and comprehensive assessment. Much as values are part of the study, the researcher strove to keep values as separate from the research as possible, to minimise researcher bias. The feminist standpoint theory provided the guiding epistemological framework to address the qualitative research questions for this study as the issues regarding reproduction are of central feminist concern. Pragmatism, which is considered a best philosophical basis for mixed-methods as it values both objective and subjective knowledge, was applied in this study.

The methodological goal of the study was guided by two paradigms, "constructivist", which is the basis of qualitative research and "contemporary empiricist" paradigms, which is the basis of empirical analytic research as the study used a mixed-method approach. Although the empiricist lens is the most appropriate for a sequential explanatory design, both paradigms are acknowledged in this study.

A quantitative-qualitative data collection and analysis sequence was followed. The sequential explanatory approach was maintained through, for example, collecting and analyzing quantitative data first, followed by obtaining information from midwives through a questionnaire and focus group discussions, and from pregnant women through a questionnaire and focus group discussions, using the same populations. Non-probability purposive sampling was done for all data sources. All data were collected by the researcher.Qualitative data analysis consisted of the identification of themes and relationships through constant comparison of data, which enabled the researcher to establish group and across-group saturation in focus group discussions.

Quantitative data was collected through the review of midwifery education regulations, documents and records. Midwives' questionnaires with a response rate of 46%, questionnaires administered to pregnant women and the review of antenatal cards with a 94% response rate. The data sets provided multiple data sources, a characteristic of the mixed methods approach. Data were analyzed using the Stata Release 10 statistical software package. Data analysis included summary statistics i.e. mean and standard deviation for continuous variables, frequencies and percentages for discrete variables, and Chronbach's alpha for internal consistency. Confidence intervals of 95% were used to report on discrete variables.

Quantitative and qualitative data were initially analyzed separately to develop an understanding of the two data bases before merging the findings and results. The process provided separate and

independent results that could be compared for the purposes of corroboration, complementarity and discussion. The results were compared for specific content areas, for example major themes.

A tool for psychosocial risk assessment and care was developed in response to the findings from the midwives' focus group discussions at the three clinics, the expert interviews findings, the cross-sectional survey results from midwives, the self-administered questionnaires for pregnant women, and review of the antenatal cards carried by women during antenatal care. The tool was piloted in the three clinics where data were initially obtained.

The general results of the study suggest that depressive and anxiety disorders are common in pregnancy and may be associated with negative experiences during antenatal care. Adequate screening of women and recognition of emotional responses with appropriate interventions are essential to promote a woman's healthy adjustment to pregnancy.

Attempts to minimise high levels of uncertainty, anxiety and depression should be incorporated within routine antenatal care.Midwives should strive to empower women physically and psychosocially in order for women to be able to overcome any barriers to safe motherhood, with emphasis on providing information, in order for them to make informed choices.The findings from the pilot study confirmed that pregnant women experience psychosocial problems which can be identified by the use of a screening tool, howeverthere remains a need to test the tool on a larger sample which might elicit more factors that could hinder or help its implementation. The implication of the findings appears to be that midwives are willing to incorporate the psychosocial assessment tool into routine antenatal care.

The findings might be used to advocate for the incorporation of the tool into routine antenatal care. While the use of this antenatal psychosocial pilot tool may increase the midwives' awareness of psychosocial risks and form a basis for further studies, a bigger sample size and statistical power are required to provide evidence that routine antenatal psychosocial assessment would also lead to improved outcomes for mother and/or child.

The final stage of the study, based on research findings, led to the development of guidelines and recommendations for psychosocial care at the midwifery regulation level, midwifery education, clinical practice level and research.

Key concepts: Antenatal care; Midwife; Psychosocial risk assessment; Psychosocial support.

DEDICATION

To God, Almighty,

Thank you for offering me this achievement.

With you by my side I strived, survived and continuously remain standing.

To you belongs all the glory!

IN MEMORY

Of my dear father Godffrey Ramathudi Mathibe
(1927-1982)

This is to celebrate your life, selflessness, kindness and support. To honour thirty years of your departure and spiritual guidance. To me you remain the best father, always. I am convinced that you, together with God's angels, have been guarding me throughout the journey as you always wanted the best for me in life, particularly academic excellence.

Let us rejoice.

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- Professor Alan Rothberg, you were more than an academic mentor and advisor. I earned another father-figure in you. In addition, you gratuitously perfected the Queen's language. Be always blessed.

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LIST OF ABBREVIATIONS

ACOG	-	American College of Obstetrics and Gynaecologists
AHNA	-	American Holistic Nurses Association
AIDS	-	Auto Immune Deficiency Syndrome
ALPHA	-	Antenatal PsychosocialHealth Assessment
ART	-	Anti-Retroviral Therapy
C	-	Case-Oriented
EXP	-	Expert
FG	-	Focus group
G1	-	Government Clinic 1
G2	-	Government Clinic 2
G3	-	Government Clinic 3
HIV	-	Human Immunodeficiency Virus
MNS 100	-	Midwifery Nursing Science 100
MNS 200	-	Midwifery Nursing Science 200
N/S	-	Not Submitted
NHS	-	National Health System
Quali	-	Qualitative
Quanti	-	Quantitative
SA	-	South Africa
SANC	-	South African Nursing Council
V	-	Variable-Oriented
VCT	-	Voluntary Counselling and Testing
WHO	-	World Health Organisation

CHAPTER 1

1. INTRODUCTION

Chapter one presents an overview of antenatal care, pregnancy and psychosocial care, the organization and content of the study, key concepts, aims and objectives, the study phases, components and sampling, paradigm perspectives and methodologies.

1.1 ANTENATAL CARE AND PREGNANCY

Pregnancy is a stressful period and as such it can put the pregnant woman at risk. Pregnancy as a developmental phase, involves both physiological and psychological adaptations which are acceptable to a certain extent, but if excessive, may lead to pathological changes. While risks cannot be totally eliminated once pregnancy is established, they can be reduced through effective, accessible and affordable maternity health care (World Health Day, 1998).

Antenatal care has been described as one of the effective forms of preventative care. It involves screening symptomatic and asymptomatic pregnant women, with the aim of detecting and thereby preventing both maternal and neonatal adverse events. The introduction of antenatal care in 1910 in the Royal Adelaide Hospital in Australia has been recognised as playing an important role in preventing high maternal and perinatal mortality rates. Antenatal care should ideally be geared towards the promotion of health and the prevention of physical and psychosocial problems (Dragonas and Christodoloulou,1998).

Pregnancy can be enhanced through a coordinated antenatal program which includes both medical and psychosocial care. Pregnant women's mental health should be a primary concern for all midwives due to a reported high prevalence of depressive and anxiety disorders in women. Goodman (2005) andHandley(2006) reported a 21% incidence of depression and 34% anxiety disorders in women, which may be exacerbated by pregnancy. Pregnancy-specific anxiety may occur as the woman worries about her pregnancy, physical changes and delivery.

The psychopathology of pregnancy needs to be understood in terms of the adjustment that all women have to make when they conceive, as pregnancy is also an adaptive process. A pregnant woman should carry the baby safely through to delivery and adjust to the sacrifices that motherhood demands. Challenges that face her include the acceptance of the pregnancy by the family; development of an attachment to the baby and preparation for birth; adjustmentto the changes in her physical appearance, and to development and maintenance

of a positive relationship with the father of the baby. Many women respond to this complex process with grief and anger, especially when the pregnancy is unplanned and unaccepted. Unmanaged grief or anger might ultimately lead to maternal depression (Gelder, Lo`pez-Ibor and Anderson, 2003).

The findings of a cross-cultural survey by Taggart and Mattson (1996) on the extent of physical and emotional abuse on African American, White American and Hispanic women during pregnancy indicated that 1 in 4 women gave a history of battering and physical abuse. The implication for this was that many women's community subsystems of safety and physical environment are not in harmony, and that battering and physical abuse during pregnancy might lead to a significant delay in obtaining antenatal care by 6.5 weeks as compared to non-abused women.

During childbirth, women may look upon their midwives as their advocates despite the existing medically-inclined maternity care context. The challenge faced by midwives is the provision of comprehensive and holistic maternity care. This challenge can be achieved through the maintenance of a woman-centred, individualised and caring approach, which needs a caring and responsive midwife. Midwifery care should involve the physical, emotional, social, spiritual and psychological elements for it to be regarded as comprehensive (Woodward, 2000).

1.1.1 **Maternal Risks during Pregnancy**

According to the World Health Organisation (1998), maternal risk is defined as the probability of experiencing various levels of injuries or even dying as a result of pregnancy or childbirth. Physiological and psychosocial risk screening should therefore be conducted during the first and subsequent visits of antenatal care as part of a comprehensive assessment during antenatal care.

The philosophy behind risk assessment is not new to midwives as they have always been mindful of the possibility of risks during pregnancy and delivery. Midwives normally use their knowledge, skills and available evidence to assess any potential risks associated with pregnancy throughout the childbearing process. This assessment should commence during the first visit, at which the midwife elicits from the woman the factors related to her medical, surgical, social and obstetrical history which may affect the outcome of the current pregnancy. Historically, the definition of maternal risk emphasizes mainly medical factors and includes few psychosocial and socioeconomic factors. To add to this, the interest of midwives seems to be

directed towards foetal wellbeing and the newborn child, ignoring the psychosocial needs of the mother. Practically, when a woman reports for delivery, her family member's concern is mostly on the wellbeing of the newborn rather than the maternal wellbeing.

Psychosocial factors are an important area to assess during pregnancy. Various studies, for example those of Dejin-Karlsson and Ӧstergren(2004), Hollander (2000), Langer (2003) and Namagembe (2007) demonstrate that stress, depression, alcohol abuse and lack of social support during pregnancy are commonly associated with low birth weight and perinatal mortality and morbidity. Furthermore, in this era of HIV/AIDS, psychosocial problems are common among affected populations. These issues may have an indirect influence by affecting antenatal care attendance, the woman's coping capacity and the physiology of pregnancy.

Most of the risk assessment systems in midwifery care focus on physical characteristics such as age, parity and education, however these assessment systems are not exclusively suggestive of a risk for maternal morbidity and mortality as they mostly exclude psychosocial factors. A review of several studies by Menon, Musonda and Glazebrook (2010) on the perceptions of antenatal care by women suggests that there are several psychosocial risk factors that need to be taken into consideration in order to ensure a safe pregnancy and delivery. Psychosocial interventions have proved to be beneficial in providing comprehensive antenatal care.

Another systematic review of sixteen studies on antenatal screening for postnatal depression by Austin and Lumley (2003) which involved twenty three thousand participants, revealed that the proportion of women who are at risk for postnatal depression was between 10% and 67%. The authors further commented that the preliminary evidence suggested that the introduction of screening tools to aid early detection and diagnosis of depression has helped to raise awareness among health care providers regarding social and psychological maternal risk factors.

1.1.2 **Possible Psychosocial Risk Factors during Pregnancy**

Smith, Brunettoand Yonkers (2004) have identified the following as some of the psychosocial risk factors that a woman may have experienced or may experience during pregnancy:

- woman battering;
- family violence or intimate partner abuse
- sexual abuse and harassment;
- discrimination;
- gender inequality
- past history of depressive disorders;
- Absent/abusive or non-supportive spouse;
- marital difficulties;
- pregnancy occurring below 18 years of age which antedates social development
- unintended, unplanned or unwanted pregnancy
- maternal or paternal unemployment;
- adverse life events, for example loss of spouse;
- socio-economic factors e.g poverty;
- barriers to accessing health care services, e.g distance travelled and transport unavailability;
- medical disorders e.g hypertension and HIV/AIDS
- Poor quality of interaction with health care providers which may lead to non-compliance to planned interventions and defaulting treatment.

The above listed risk factors can directly or indirectly affect the outcome of pregnancy in a negative way(World Health Organization, 1998). A meta-analysis of perinatal depression identified depression as a major complication of pregnancy affecting 14,5% of pregnant women (Handley, 2006).

1.1.3 **Why Psychosocial Risks should be Screened during Antenatal Care**

The concept of psychosocial stressors during pregnancy encompasses life experiences, including amongst others, changes in personal life, job status, family make-up, housing and domestic violence. All these require adaptive coping mechanisms on the part of the pregnant woman, which can be achieved through the support of the midwife.

Risk screening, according to WHO (1998) involves using a list of risk factors and some form of scoring system to classify pregnant women into specific risk categories, typically high risk or low risk, using cut off points or thresholds. The focus of risk screening is to detect early symptoms and to predict the likelihood of complications. The intention of risk assessment is to

predict problems before they occur and as such, take appropriate action by providing optimal maternal care.

Bibring (1959)as cited by Dragonas et al (1998)was amongst the first psychoanalytic writers to claim that “pregnancy is a psychobiological crisis affecting all expectant mothers, no matter what their state of psychic health. As [with] every normal crisis that constitutes a turning point in life, it precipitates an acute disequilibrium . . . may lead to a new level of psychological maturity and integration. The outcome of this crisis might have a profound effect not only on the woman herself but also on the mother-child relationship.”

Psychological morbidity is not given enough recognition, it is not thought to be self-limiting as it is the care that is attributed to normal emotionality of pregnancy, and it is less frequently identified, especially if there is no continuity of care by the same midwife. Willinck and Schubert (2000) reported that antenatal depression affects 4-16% of women, domestic violence during pregnancy rates at 16%, and postnatal depression affects 15-20% of postpartum women. The statistics for postnatal depression might be currently higher than what was reported by Willinck et al(2000).

A cross-sectional study to identify a relationship between life stress, perceived social support and symptoms of depression and anxiety was conducted by Glazier, Elgar, Goel, Holzapfel (2004). Based on their findings, they recommended that psychosocial assessment of pregnant women and their partners may facilitate interventions to augment support networks, and as such reduce the risk of psychosocial stress.

The New Antenatal Care Model proposed by WHO (Fawole, Okunlola and Adekunle, 2008) recommends the following set of activities during each visit for those who are identified to be at low risk: screening for conditions likely to increase adverse outcomes of pregnancy; providing therapeutic intervention known to be beneficial, and educating about safe birth including possible emergencies during pregnancy and how to deal with them. It does not emphasise psychosocial issues but proposes that some time should also be made during each visit to discuss the pregnancy andrelated issues. Emphasis is also put on the importance of communication.

As a measure to promote psychosocial risk assessment, a new approach to psychosocial risk assessment during pregnancy (ANEW), was implemented in Australia during 2000, in a form of

a project to provide an alternative way to psychological risk screening in pregnancy. A training program in advanced communication skills and common psychosocial aspects of childbirth was offered to midwives and doctors at the Mercy Hospital for women, with the aim of improving the identification and support of women with psychosocial needs in pregnancy (Gunn, Hegarty, Nagle, Forster, Brown and Lumley2006).The outcome of the program was that it improved the ability of the health care professionals to identify and care for women with psychosocial problems.

The outcome of group sessions in a study done by Rothberg (1991a) on the effects of stress and counselling on birth-weight, was that having a social worker as part of the antenatal team helped to provide a more personal and caring contact. Ithad a positive effect for the mothers during pregnancy and had an effect on birth-weight.

Midwives are urged to overcome the perception in literature and media that health care providers are unkind, rude, unsympathetic and uncaring, as negative emotions such as anger may arise when a woman receives insensitive care. Hildingson and Radestad (2005) concluded their study of Swedish women's satisfaction with medical and emotional aspects of antenatal care by urging midwives working in antenatal care to support pregnant women and their partners in a professional and friendly way in order to increase their satisfaction with care. They also advised that identifying and responding to women who are dissatisfied with their antenatal care could help to improve their satisfaction.

In theory, risk assessment is a logical tool for rationalising service delivery to ensure that those in greater need receive special attention and care. However, it is becoming increasingly clear that with incorrect and inadequate risk assessment, scarce resources may be diverted away from pregnant women who are in real need. In the absence of evidence of an effective risk screening process, risk assessment cannot be relied on as a basis for matching needs and care in maternity services (World Health Organization, 1998)

Ideally, psychosocial risk assessment should be included within the overall risk assessment, or could be administered as a separate tool in the form of a checklist. The tool should, for example, screen for economic, social, psychological and emotional stressors, domestic violence, history of sexual abuse and substance abuse.

1.1.4 **The Impact of Pregnancy on Maternal Wellbeing**

- **The physiological effect of pregnancy**

  Pregnancy may have an enormous psychological and physiological effect on a woman's body and mind. This is due to suppression of the hypothalamic-pituitary-adrenal axis, which leads to dramatic changes in oestrogen and progesterone levels. Changes in these hormone levels may alter a pregnant woman's coping mechanisms. The physical discomfort of pregnancy, accompanied by anticipation of childbirth and the responsibility of parenthood, often causes anxiety and emotional changes (Mamelle, 2001).

- **Stress alters physiology**

  There is a growing body of data suggesting that psychosocial factors such as high stress and low social support negatively affect the success of pregnancy. The findings of a survey by Coussons-Read, Okun and Nettles (2007) to address relationships between psychosocial variables and serum inflammatory markers during pregnancy, support the notion that prenatal stress alters maternal physiology and immune function in a manner that is consistent with an increased risk of pregnancy complications such as preterm delivery and pregnancy-induced hypertension. The conclusion based on the findings of the above survey was a need for the development of strategies for supporting maternal mental health.

- **The expectations of pregnant women**

  The need for psychosocial care during childbirth is supported by the researcher's findings in a phenomenological study in a Pretoria Academic Hospital, into the expectations of antenatal care by pregnant women. Most women were happy with the physical health care they received but were dissatisfied with not being involved with the management of their pregnancy, their experience of inadequate guidance, ineffective communication and lack of punctuality at follow-up appointments given to them (Baloyi, 2002).

1.1.5 The impact of Psychosocial Stress on Maternal and Foetal Wellbeing

It is clear that birth and infant development are affected by prenatal events that could lead to maternal stress. Maternal psychosocial stress has been recently identified as a factor in early foetal development. There is growing evidence that peri-natal psychological and environmental stressors are detrimental to pregnancy success and infant outcomes. Stress is often defined as events, situations, emotions and interactions that are perceived as negatively affecting the wellbeing of an individual, or that causes responses that are perceived as harmful(Coussons-Read, Okun, Mischel and Scott 2005).

A direct relationship is said to exist between maternal psychological stress and low birth weight, prematurity and intra-uterine growth retention.This is related to the release of catecholamines which results in placental hypo-perfusion and consequent restriction of oxygen and inhibition of nutrients to the foetus, leading to foetal growth impairment (Rondo, Ferreira, Nogueira, Lobert and Artes 2002).

1.1.6 The Relationship between Antenatal Depression and Postnatal Depression

There is considerable evidence that postnatal depression is a public health care challenge as it can become chronic, can damage the relationship between the woman and her partner, and might have adverse consequences for the emotional and cognitive development of the newborn. Regular assessment of mood during pregnancy should be routine for all women to establish the risk for depression, as postnatal depression can recur. Antenatal mood assessment is one of the most robust predictors of postnatal depression, as fifty percent of postnatal depression is reported to have begun during pregnancy (Raynor, Sullivan and Oates, 2003).

Recommendations from a survey by Targatand Mattson (1996) were that a search for battering and abuse should be carried out during the antenatal assessment of pregnant women and midwives should have knowledge of the appropriate interventions and be familiar with the resources for referral. The increased cost and complications that may arise as a result of any delays should be a concern for maternal-child health professionals.

There is evidence from research that women with antenatal psychosocial risk factors are more likely to have a postnatal mood disorder, and as such, antenatal assessment can be beneficial for these women. The early identification and management of psychosocial risk factors has been shown to be beneficial in various studies. For example, in the study of Matthey (2005) review of existing tools that are used to assess psychosocial morbidity in pregnant women, and Hamid, Asif and Haider's (2008) study on anxiety and depression during pregnancy, outcomes were improved by minimising the occurrence of postpartum depression.

Routine antenatal and postnatal screening for psychosocial distress or depression has been supported by investigators as a preventive measure for postnatal depression. The Edinburgh Postnatal Depression Scale is a commonly used tool for assessing postnatal depression, but is

usually only implemented when a need arises, for example when the woman indicates that she has a problem (Matthey, 2005).

1.1.7 The Importance of Psychosocial Support during Pregnancy

Inadequate psychosocial risk assessment may lead to lack of psychosocial support afforded to the pregnant women by midwifery and social support services during pregnancy and childbirth. Pregnant women who lack psychosocial support may experience stress during their pregnancy and childbirth. These changes may increase the woman's vulnerability to depression, which may in turn have adverse effects on both maternal and foetal wellbeing (Suppaseemanont, 2006). Unrelieved stress can also increase vulnerability to physical and emotional problems, for example insomnia, fatigue, ulcers and heart problems (World Health Day, 1998).

Supportive care during childbirth may have long term positive effects and may protect some women from a long-lasting negative birth experience. The latter was found in a longitudinal cohort study on why some women change their opinions about childbirth over time (Waldenstrom, 2004). Mixed feelings were elicited from women regarding their attitude towards childbirth, changing from positive to less positive opinions based, for instance, on painful labour, dissatisfaction with intra-partum care and psychosocial problems such as single marital status or the presence of depressive symptoms. Changing from negative to less-negative feelings was associated with less worry about birth in early pregnancy and a more positive experience of support by the midwife.

According to Feldman (2000), psychosocial support not only lowers prematurity and low birth weight rates, it can also inspire healthier behaviours and lifestyles among pregnant women and discourage behaviours like smoking, substance abuse and poor nutritional intake which can have other detrimental effects on the mother and baby. Psychosocial support calls for a multi-level approach, consisting of strengthening partners and families and enhancing system capacity by ensuring the availability of resources. Interventions need to bolster the support provided within the woman's existing social network in order to maintain the woman's cultural beliefs and values.

Coussons-Read et al (2005) tested a hypothesis on the relationships between psychosocial stress, social support, self-efficacy and circulating pro- and anti-inflammatory cytokines in women throughout pregnancy. Pregnant women within the study completed the Denver Maternal Health Assessment. The conclusion was that high social support was associated with

low stress scores. Elevated stress scores positively correlated with higher levels of pro-inflammatory cytokines interleukin-6 (IL-6) and tumour necrosis factor- α (TNF-α).

A longitudinal community based study conducted by Seimyr, Edhborg and Sjogren (2004) through the use of the Edinburgh Postnatal Depression Scale (EPDS) revealed that women who lacked social support showed more symptoms of depressed mood. The maternal depressive mood had a negative impact on breastfeeding, the experiences of motherhood and the relationship with partners.

The Confidential Enquiries into Maternal Deaths Report (CEMD, 2001), highlights that not all women identified as being at risk actually experience adverse outcomes, but even when a woman at risk is identified, appropriate action is not always taken. Appropriate assessment is important for designing appropriate intervention strategies and for public health policy formulation (Dejin-Karlsson et al 2003).

Ethically, psychosocial risk assessment should be linked to a plan of care through the provision of appropriate psychosocial support. The plan of care should ensure that the maternal referral arrangements are in place at the participating facilities. The plan of care should be coordinated with all appropriate disciplines.

The identification of psychosocial risk factors would allow an opportunity to offer basic psychosocial support or refer the woman for more specialised psychosocial support. With the increasing rate of HIV/AIDS and family violence, there is a dire need for psychosocial support by midwifery practitioners for the pregnant women who are infected or affected. The issue of psychosocial risk assessment and support seems to be a concern both nationally and internationally. The WHO also recommended that pregnant women should be supported by social workers in order to improve perinatal health (Willincket al,2000).

1.1.8 **The Evolution of Antenatal Care**

Antenatal care is about 100 years old, a national system that is based on routine visits to an obstetrician or midwife. The first antenatal clinic was established in the Royal Adelaide hospital in 1910, but from the onset it became an international movement. The origin of formalized antenatal care was based on the concern around population decline and infant morbidity and mortality.

Part of the evolution dates back to 1915 when a Bill was passed by the Congress of Children's Bureau in the United States of America, aimed at improving women's understanding of what constitutes ideal prenatal and obstetric care, and at making resources available to achieve these goals. The Children's Bureau further highlighted the fact that teaching women to care for themselves during pregnancy would assist in reducing infant mortality (Dragonas et al, 1998).

The nature, development and progress of antenatal care resulted from scientific, political and cultural perspectives, which are currently important in restructuring antenatal care that serves both pregnant women and midwives.

Factors that contributed to the origin and shaping of antenatal care included women's pressure groups that represented women at large, general practitioners, obstetricians and midwives. Through this joint effort, the outcome of antenatal care was directed towards awareness, prevention and management of obstetric and medical complications.

1.1.8.1 **The aim of antenatal care**

Antenatal preparation should be offered to all women during pregnancy as a national policy. Screening during pregnancy is crucial, with the aim of detecting and preventing both maternal and neonatal adverse events and instituting early intervention. During screening, midwives should actively listen to the concerns and needs of pregnant women to be able to assess them comprehensively. Assessment and management can be achieved through the 'GATHER' concept as described by Baldo (2001). "GATHER" which implies "greet, ask, tell, help, explain and return for follow up" (Mehdizadeh, Roosta, Chaichan, Alaghehbandan 2005).

Antenatal screening for risk factors is also directed towards the early identification of women and families at risk, as the woman is part of a family. This is necessary to ensure appropriate and prompt referrals tailored to meet the needs of the women and also of their families. A pregnant woman should have continuous risk assessment throughout and until the end of pregnancy, as risk status is dynamic and may change over time. This would allow the woman and her caregivers to constantly review and possibly revise the plan made for childbirth (O'Keane and Marsh, 2007).

Most antenatal care models put emphasis on the physiological or medical risks of pregnancy, with little or no attention to psychosocial risks. The careful assessment of pregnant women

during the antenatal period, noting the past and the current history and how this history may affect the pregnancy, might be a good way of identifying vulnerable groups.

A British study done during 1996compared the traditional patterns of antenatal care with the reduced schedule of visits for women with low risk pregnancies (Baldo, 2001). Results indicated that fewer antenatal care visits led to poorer psychosocial outcomes and greater maternal dissatisfaction. ACochrane review, as referred to in this study, also noted that although most women were satisfied with the reduced visits, some felt that their expectations of antenatal care were not met. The implication for the findings was that there is a need for appropriate psychosocial risk assessment and support during the reduced schedule of four antenatal visits.

According to the Clinical guideline (2003), antenatal care is not an independent entity as viewed from a midwifery perspective. It is an integral part of the whole childbearing experience which marks the beginning of a journey that midwives and women will undertake. It is a time when a partnership is negotiated, roles and responsibilities are identified, information is shared, options are discussed and choices are made.

As the principles of antenatal care were adopted over a century ago, their ongoing relevance, validity and maintenance can best be supported through rigorously testing them against the best currently available evidence (Dodd, Robinson and Crowther, 2002).

1.1.8.2 **Antenatal care within the South African context**

Traditionally and in many contemporary contexts, including South Africa, antenatal care consists of a prescribed set of acts based around the clinical monitoring and screening of all pregnant women. This establishment of routine care was based on the notion that pregnancy is a state of pathology rather than normal physiology. There is evidence of a focus on technological dominance and a focus on the detection of obstetric and medical conditions occurring during pregnancy. This is based on a review of seven guidelines for antenatal care from the USA, Canada, Australia and Germany, and mostly reflect expert opinion rather than scientific evidence(Stahl and Hundley, 2003).

Antenatal care in South Africa is provided at the primary, secondary and tertiary levels of care in both the public and private healthcare systems. Since 1994 antenatal care has been free for women who use government facilitiesin South Africa, as recommended by the National Health

System Committee (National Health Bill, 2002). Women in urban areas have options regarding where to seek antenatal care. Antenatal care in the public sector that also serves private patients, is basically provided by a Midwife Obstetric Unit (MOU) or as part of a comprehensive primary health care service. The service is also provided by private midwives or by obstetricians for privately funded or insured women.

The highest percentage of antenatal care is offered by midwives in primary health care settings, with a Medical Officer of Health reviewing high risk pregnant women. Basic antenatal care services include physical examination, weight measurement, urinalysis, blood pressure monitoring, blood investigations and health information, and are supposedly provided at all levels of antenatal care as routine practice. Ultrasound services are only available in tertiary hospitals and private sectors. Prenatal care activities in South Africa are documented in a hand held antenatal record.

The ongoing debate on antenatal care regarding its frequency, content, continuity, quality and effectiveness in reducing maternal and neonatal morbidity and mortality, led to a new evidence-based protocol on the frequency of antenatal care. This is the result of randomised trials carried out in the United Kingdom and Zimbabwe and of the World Health Organisation trials in Thailand, Argentina, Cuba and Saudi Arabia during 1996 (Baldo, 2001).

The new schedule, as recommended by WHO(Baldo, 2001), consists of four visits during pregnancy, the first one being early in pregnancy, with subsequent visits at 26, 32 and 36 weeks. This schedule is designed for the pregnant woman at low risk. These fewer antenatal visits led to poorer psychosocial outcomes and drew attention to greater maternal satisfaction with the routine care that was previously provided. The question is whether there would be an opportunity for the midwives to address psychosocial assessment and care within this regimen?

The current number of antenatal visits for Gauteng Province, as indicated within the Gauteng Department of Health Antenatal Care Policy Document (1999), is actually eight visits for low risk pregnancy (which is double the number of recommended visits by The World Health Organisation). Is psychosocial risk assessment adequately and properly conducted during this eight antenatal care regimen? Do pregnant women receive psychosocial support during pregnancy? These are some of the questions that this study will attempt to answer.

The Changing Childbirth report explicitly confirmed that women should be the focus of antenatal care to enable a woman to make informed decisions based on her needs having discussed her matters with the midwife involved. Key aspects of care valued by women are reported to be respect, competence, communication, support and convenience (NHS, 2007). Raynor et al (2003) further clarified that the environment for interaction, i.e the antenatal clinic, needs to be safe, both personally and culturally, and should also afford adequate privacy.

It is also important that the schedule of the visits is one that both the woman and the midwife feel relaxed and comfortable with, and appointments should be arranged attimes convenient to the pregnant women. The aims of antenatal care may differ for women and midwives, and the perceptions of both should consequently be incorporated into the ideal model of psychosocial care. This can be managed through the collection of data from both parties and other stakeholders as reflected within this study.

1.1.9 The Development of Midwifery in South Africa

South Africa became the first country in the world to register midwives in 1891. Midwifery registration was initially voluntary prior to the South African Nursing Council taking over as the regulatory body in 1944. Only males who were also qualified as doctors were allowed to register, and only single women were allowed to train as midwives (Nevhutalu, 2004).

The following table highlights the development of midwifery in South Africa.

Table 1.1: The development of Midwifery in South Africa

The development of midwifery	Year
Registration of midwives	1891
Midwifery education for whites only, founded by Mary Hirst Watkins	1893
Midwifery education for Coloureds and Asian women	1917
Midwifery education for black women	1927
Allowing married women into the midwifery education program	1960
Admittance of males to midwifery training	1967
All midwives required to train as general nurses, no direct entry allowed into the midwifery program	1968
Formation of the National Society of Midwives in Southern Africa	1988
Report on maternal deaths	1997

(Nikodem, 1998)

1.1.9.1 **Midwifery education in South Africa**

There are two main avenues for nurse training in South Africa,with basic midwifery integral to both.One is through enrollment at a nursing college for the four-year diploma in Nursing (General, Psychiatric and Community) and Midwifery. A grade 12, secondary schooling certificate is required for this enrollment. The other is througha Bachelor's degree that requires an exemption certificate for entrance to a University program. A post basic diploma in Advanced Midwifery and Neonatal Nursing is also available. A higher level qualification in Midwifery is offered in the form of a Masters Degree, a Doctor of Philosophy or a Doctor Curationis as an academic and not as a professional degree, which respectively includes a research report, dissertation or thesis. The International Childbirth Educators Certificate in perinatal education is also offered as an extended course in midwifery care.

Once the Midwife has qualified and registered, she can opt to practice within a health care setting or establish a private practice. The midwife is expected to practice within regulations stipulated by the South African Nursing Council (R2598 of 1984).

There are allied organizations that participate in the growth, development and promotion of midwifery practice, and in research and childbirth education in South Africa, for example:

- The Society of Midwives of South Africa,
- The Midwifery HIV/AIDS Alliance,
- Midwifery Forums in each of the nine provinces
- The Association for Childbirth and Parenting
- The Sensitive Midwifery Society
- The Perinatal Education Network

1.1.9.2 **The position and the statutory control of midwifery practice in South Africa**

The South African Nursing Council controls midwifery education and the scope of midwifery practice in South Africa. Midwifery is offered by midwives in government and private hospitals, or by obstetricians. The role of a midwife as an independent practitioner is not completely implemented in private hospitals as she is typically dependent on the obstetrician to make decisions and prescribe care. However, there are private facilities that cater for the midwife as the primary caregiver who would refer the woman to a medical practitioner only in the event of a complication.

1.2 PSYCHOSOCIAL CARE: A MISSING PIECE OF THE ANTENATAL CARE PUZZLE

1.2.1 The Background of the Study

It appears that psychosocial risk assessment and psychosocial support are given insufficient attention during pregnancy, in spite of the possible factors that might lead to psychosocial maladjustment during pregnancy, as cited in the literature. These are some of the researcher's observations as a midwife:

- Midwives are mostly confined to routine care that emphasises the physiological aspects of pregnancy.
- The current clinical record for assessment during antenatal care has a column in which to list problems, however the focus is mostly on medical problems.
- The Gauteng Health Department's antenatal care policy has limited guidelines or recommendations for psychosocial care
- The education of midwifery students addresses the psychosocial aspects of care to a very limited extent.
- The theoretical assessment of midwifery students, as reflected in the question papers of nursing colleges, universities, and those of the South African Nursing Council for post-basic midwifery education, does not often include psychosocial assessment and care.
- Pregnant women attending antenatal care in government hospitals are deprived of psychosocial care as the focus is on routine medical/physiological care

The above are supported by the researcher's findings from a phenomenological study on the expectations of antenatal care by pregnant women. Most women were happy with the physical health care but were dissatisfied with interpersonal aspects, for example involvement, guidance and communication from the health care providers (Baloyi, 2002).

As a midwifery lecturer, the researcher often accompanies students for clinical facilitation. On guiding students in the psychosocial assessment and psychosocial care of women in the antenatal clinic, women frequently verbalize social and emotional concerns. The researcher's further experience is that if psychosocial assessment is indeed conducted on a pregnant woman, it usually elicits current active and significant issues for the pregnant woman.

The following are common remarks that were expressed by women during their antenatal visits whilst the researcher was engaged in student accompaniment.

A woman carrying her first pregnancy, gravida 1 para 0, from one of Gauteng's provincial hospital's antenatal clinic remarked:
"No one ever asked me this. Why don't everyone do like this? Ithink I am lucky today, I had so much to ask or discuss previously but there was just no one to listen to me. I moved from a black hospital to a one for whites thinking things will be better but it's the same. We come here, they quickly check the baby, and within 30 minutes you are gone with so much to share, as if the baby isthe only one important". She then asked for the lecturer's and thestudent's contact numbers.

A pregnant woman, 42 years old, was asked if the pregnancy was planned at this vulnerable age as her first child was 20 years old. Her response was that she had lost a husband five years ago and had recently married. She was coping but the only problem was that the first child was rejecting both the new husband and the pregnancy. This was a reflection of another need for psychosocial support which could have been achieved through a proper psychosocial risk assessment and appropriate referral. Some of the psychosocial behaviours that can be identified during assessment reflect shock at the discovery of an unplanned pregnancy, emotional difficulties in dealing with unwanted pregnancy, lack of support, depression and career or job loss.

The focus for this study is on psychosocial risk assessment and psychosocial care, as it appears to be given inadequate attention as compared to physiological risk assessment and care. As stated by Dragons et al (1998), the recent development of more sophisticated equipment, and laboratory innovations and techniques are directed towards the identification and the management of medical complications, with progressively less attention directed towards the psychological and social wellbeing of the pregnant woman.

The opinions of Handwerker (1994), Lupton (1999), Saxell (2000) as cited by Stahl and Hundley (2003) were that risk assessment during childbirth is made more complex by the differences in the perceptions of risks between midwives and pregnant women, as risk from a midwife's perspective is based on her specialised knowledge and training, epidemiology, personal values and experience, whereas a woman's understanding of risk is far more contextual , individualised and embedded in her social environment and everyday life experience.

1.2.2 A Personal Experience of Lack of Psychosocial Support

My first pregnancy, in 1985, was unintended but accepted, the outcome of a failed contraceptive method. The pregnancy posed a challenge regarding the maintenance of the pregnancy as I was a single parent, emotional support was limited and my mother, (the only surviving parent at the time) did not accept the pregnancy as she observed a cultural taboo of bearing a child out of wedlock. With a partner who was inclined towards termination of the pregnancy, adoption seemed to be a better option for me.

As the pregnancy progressed I chose to exercise my choices and rights and kept the pregnancy, which led to me being on my own without the father's full support. There was no midwife to talk to. Antenatal care was just an outing to socialise with other pregnant women, but no woman was encouraged to share her concerns during these visits. Labour, which was prolonged due to a posterior position, was very painful, with no analgesics given and no non-pharmacological pain relief measures. By the time I was referred to the community hospital I was no longer sure if I still wanted the baby. The postnatal period, after a vertex delivery that I would not regard as normal, was even less welcome. I did not feel the need to see the baby. I did not want to breastfeed. I just lay in bed all the time. No bonding took place.

The baby developed neonatal jaundice due to inadequate feeding. That was a "wake up call" for me, and I initiated breastfeeding. The maternity manager engaged with me to establish my problem. Was that perhaps not too late for psychosocial risk assessment? After two weeks of unnecessary hospitalisation with postpartum depression, I luckily walked out with my baby still alive, and I became fully committed to breastfeeding.

As a single parent, I had to return to work within three months of the delivery in order to secure finances to raise the baby. With the introduction of formula feed, "nipple confusion" developed and the baby rejected the breast and chose formula feed. Although not evidence-based, the mother-daughterrelationship was never well established, probably because of lack of bonding from conception and the experience of a stressful and non-supported labour process. How many pregnant women have silently experienced the same situation without anyone to share their anxiety, concerns or confusion with?

1.2.3 The Need for Psychosocial Care during Pregnancy, as Reflected in theLiterature

Baldo (2001) in a review of the antenatal care debate, quoted Mcllwaine (1980) highlighting that he was amazed that pregnant women came for antenatal care and waited in the clinic for two hours, only to be seen for two minutes by someone laying his or her hands on them, and then leave. The reason for this is the traditional focus on the biophysiology of pregnancy. He recommended that antenatal care appointments should be structured and focused, and advocated for longer first appointments to allow comprehensive assessment in order to address both physiological and psychosocial risk factors.

In a randomised controlled trial by Carroll, Reid, Biringer, Midmer, Glazier, Wilson, Permaul, Pugh, Chalmers, Seddon and Stewart(2005), in examining the effectiveness of the Antenatal Psychosocial Health Assessment (ALPHA) form in detecting psychosocial risk factors in pregnant women, revealed that 72.7% of the women in the ALPHA group showed interest in discussing issues. The experimental group was twice as likely to declare psychosocial problems as the control group (based on odds ratio 1.8, 95% confidence interval and 1.1-3.0, ρ = 0.02).

Two-thirds of health care providers in the ALPHA group found the form easy to use, and 86% said they would use it if it were recommended as standard practice. The conclusion of the trial showed that the assessment of psychosocial wellbeing during antenatal care was acceptable to both women and health care professionals.

Willinck et al (2000) in a project on antenatal psychosocial risk assessment in Australia, stated that antenatal depression, domestic violence and postnatal depression occurred more frequently than gestational diabetes, placenta praevia, pre-eclampsia and other obstetric and medical conditions, but most midwifery care settings still do not routinely screen for psychosocial problems.

1.3 THE ORGANISATION AND CONTENT OF THE STUDY

The organisation of the study was according to the framework of mixed-methods research which are: research aim/goal, objectives, mixing rationale, questions, sampling design and mixed-methods design.

1.3.1 **The Aim and Purpose of the Study**

The aim of this study was to develop guidelines for the enhancement of psychosocial risk assessment of pregnant women, with a focus on the provision of psychosocial support. Based on Newman et al's framework of mixed-methods (Onwuegbuzie and Leech, 2006), the goal of the study was to better understand the phenomenon of psychosocial care during pregnancy, to add to the knowledge base of psychosocial care and to have a social and institutional or organizational impact.

The overall purpose of thestudy was therefore to address a pregnant woman's psychological status, to the benefit of her foetus and her own postnatal wellbeing. This would be affected through the introduction of an antenatal risk assessment program that would identify and manage women and families that are psychosocially at risk.

It was hoped that the results and findings of the study would provide evidence which could motivate interventions aimed at closing the gap between the routine assessment of physiological risk factors and the assessment of psychosocial risk factors during antenatal care. This would provide a basis for midwives to implement an appropriate action should any psychosocial risk be identified. Once formally tested, such guidelines could be incorporated into national guidelines for best practice.

1.3.2 **The Objectives of the Study**

Four of five major standard objectives for mixed-methods research were applied to this study viz. explanation, exploration, description and influence (Onwuegbuzie et al, 2006). Explanation and description were applied to the quantitative phase, whereas exploration, description and influence were linked to the qualitative phase, with the latter relating to the manipulation of the setting through piloting developed guidelines to produce the desired outcome of psychosocial care.

- To establish the extent of psychosocial risks during pregnancy.
- To explore and describe the midwifery content designed to educate students regarding psychosocial assessment and care of pregnant women.
- To explore and describe the awareness and knowledge of psychosocial risk assessment and psychosocial care by midwifery care providers during pregnancy.
- To explore and describe the experiences and satisfaction of pregnant women regarding psychosocial care offered during antenatal visits.

- To develop recommendations in the form of guidelines that would focus on psychosocial risk assessment and psychosocial support during antenatal care.
- To pilot the formulated guidelines.

1.3.3 **Research Context and Methods**

A mixed-method research was used for this study. A sequential explanatory design, whereby quantitative data were first collected and analyzed, followed by qualitative data collection and analysis in two consecutive phases. The investigation was conducted within the following contexts:

1.3.3.1 **Data collection**

- Midwifery education and training regulations from the South African Nursing Council were reviewed to establish the inclusion of psychosocial care.
- Education and training records of the three nursing colleges providing basic nurse education in Gauteng province in South Africa.
- Records of antenatal care for women attending Government antenatal facilities in Gauteng province.
- The administration of questionnaires to pregnant women attending antenatal care in Gauteng province clinics.
- Focus group discussions with both midwives and pregnant women at the antenatal care clinics.
- A survey to establish the extent of psychosocial assessment and psychosocial care by midwives during pregnancy, through a self-administered questionnaire which was conducted at the 8th Annual Congress of Midwives of South Africa, at which midwives from the nine Provinces were represented.
- In-depth interviews were conducted with midwifery experts from various settings at which midwifery was offered, for example universities, nursing colleges and Midwifery Obstetric Units (MOU) and clinics.

1.3.4 **Paradigmatic Perspectives**

1.3.4.1 **Philosophical assumptions**

The study is based on the researcher's values and belief of holism and comprehensive assessment philosophies. Much as values are part of the study, the researcher strove to keep her personal values as separate from the research as possible to minimise researcher bias. The central nursing theories that will be applied throughout the whole study are that of Virginia

Henderson's four constructs and Jean Watson's Theory of Human Caring, which focuses on the art and science of human caring. Of Henderson's fourteen components of basic needs, the 10th, 12th, 13th and 14th components form the basis of this research as they involve the sociological and the psychological aspect of health care.

Henderson's focus is on the holistic approach, emphasising the mind, social and spiritual aspects of a pregnancy. Her argument is that nursing care is mostly fitted into the physician's therapeutic plan which is medically inclined and mostly addressing physical care, and as such compromising the holistic approach to health care. Furthermore, she views health as a vital need that requires independence and interdependency also influenced by internal and external factors.

Jean Watson's theory is based on humanitarian, metaphysical, spiritual-existential and phenomenological orientation that draws from Eastern philosophy (Watson, 1979;Fawcett, 2002). Her theory offers a way of conceptualising and maximising human-to-human interaction that is central to nursing. Watson further states that "health refers to unity and harmony between the body, mind and soul, with the goal of nursing being to help a person to gain harmony with the body, mind and soul. Watson's theory consists of ten care related factors. Three of the ten factors serve as philosophical basis for the science of caring whereas the remaining seven provide specific direction for nursing interventions.

The following philosophical bases were also applied:

- Florence Nightingale (Light,1997)had a belief of nursing education as a framework inclusive of illness and health. She also encouraged a supportive environment to enhance nature's healing process.
- Abraham Maslow's Hierarchy of Human Needs (McLeod, 2007) which explains the progression of human needs, from the basic physiological need to self-actualisation.

The feminist standpoint theory provided the guiding epistemological framework to address the qualitative research questions for this study, as the issues regarding reproduction are of central feminist concern.

1.3.4.2 **Methodological assumptions**

Methodological assumptions are concerned with the nature and the structure of science and research, including the preferences and assumptions of the type of research study

(Mouton,1996). The goal of the study was guided by two paradigms.“Constructivist”,(which is the basis of qualitative research) and “contemporary empiricist”, which is the basis of empirical analytic research (Burns and Grove, 2007). Although both paradigms are acknowledged in this study, the empiricist lens is the most appropriate for a sequential explanatory design.

The constructivist paradigm is guided by the epistemological view that the truth varies.It is determined by individual participants in the study, as applied to establish the perception of psychosocial care by both the midwives and pregnant women. What is important and true for the women might not be so for midwives. Furthermore, the constructivist ontological view, that there are multiple realities that are influenced by culture and the environment, is also applied in this study. The purpose of the empiricist view is to statistically describe and explain the psychosocial care coverage in midwifery care.

The four sources of knowledge based on epistemology were applied to this study as follows:

- Intuition, by the researcher presenting the initial idea of the study and its value;
- Empirical, by engaging in multiple procedures that led to qualitative findings and quantitative results;
- Authoritative, through the review of relevant literature; and
- Logical, by reasoning from obtaining data and interpreting findings to conclusions.

Pragmatism, which is considered a best philosophical basis for mixed methods as it values both objective and subjective knowledge (Hanson, Plano Clark, Petska, Creswell and Creswell 2005; Onwuegbuzie and Johnson, 2006), was applied in this study.The purpose, methods and the criteria for trustworthiness are also taken into consideration. A functional approach within this study context relates to psychosocial assessment and care during pregnancy, which fulfils the pragmatic aim of the practice of science by stating that valid knowledge must be utilised through application in practice in order to improve that practice. A pilot test was done on psychosocial assessment and psychosocial support by midwives during antenatal care as a form of a functional approach. The researcher adhered to logic and justification throughout the research process. The philosophical standpoints for the study are discussed in Chapter two.

1.3.5 **Key Concepts**

1.3.5.1 **Psychosocial risks**

Psychosocial risks are described as the demands or challenges that are psychological or social in origin, having the potential to directly or indirectly alter homeostasis during pregnancy

and childbirth (Stahl et al, 2003). It relates to a combination of the affective states and cognitive factors of anxiety, depression, self-esteem mastery and perceived stress as measured by the scale of Goldenberg, Hickey, Cliver, Gotlief, Woolley and Hoffman (1997).

According to Shamim ul Moula (2009), a psychosocial problem may occur in response to an exposure to a stressful lifeevent, for example unemployment. The psychosocial response will however be determined by the effect it has on an individual, for example loss of self esteem and feelings of worthlessness.

1.3.5.2 **Psychosocial assessment**

This is defined as an evaluation of an individual's mental health, social status and functional capacity. The individual's physical status, appearance and modes of behaviour are observed for factors that may indicate or contribute to emotional distress or mental illness. Observation includes posture, facial expressions, manner of dress, speech and thought patterns, degree of motor activity and level of consciousness. The individual is questioned concerning patterns of daily living, including work schedule and social and leisure activities. Data should include the individual's response to and methods of coping with stress, relationships, cultural orientation, unemployment or change of employment, change of residence, marriage, divorce, or death of a loved one (Anderson, Harris and Madl,1998).

1.3.5.3 **Midwife**

A midwife is defined by SANC in Regulation 2598 of 1984 as amended, as a person who has been regularly admitted to midwifery education and practice by means of the prescribed course of studies in a midwifery educational programme that is recognised in South Africa. In addition, she has successfully acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery through the South African Nursing Council. She further has an important task in health counselling and education, not only for women but also within the family and community. The work should involve antenatal education and preparation for parenthood. She may practice in hospitals, health units, and domiciliary conditions or in any other ideal situations (Nolte, 1998).

1.3.5.4 **Pregnancy**

This is a gestation process which comprises the growth and development within a woman of a new individual from conception, through the embryonic and foetal periods to birth. This lasts

approximately 266 days from the day of fertilisation. Clinically the process is considered to last for 280 days (Churchill Livingstone Dictionary of nursing, 2006).

1.3.5.5 **Antenatal care**

Antenatal care is part of reproductive health, covering care that is given to a woman from conception until the onset of labour. In South Africa, it is usual for a midwife or an obstetrician to provide such care, although it may also be provided by a general practitioner or a family medicine practitioner. The overall objective of antenatal care is to ensure the best possible pregnancy outcomes for pregnant women and their offspring, thorough optimal physical, social and psychological preparation before delivery. A complete assessment should be done during this period(ANON 2000), Gauteng Department of Health Antenatal Care Policy Document (1999)Mosby's Medical, Nursing and Allied Health Dictionary (1998).

1.3.5.6 **Psychosocial support**

This involves the comfort, assistance and information one receives through formal and informal contact with individuals or groups (Bryce, Stanley and Enkin, 1988).

The focus within this context is on providing information, support and, where indicated, referral for psychological and social intervention. For the purpose of this study, support implies interventions that are rendered by midwives to reduce stress in a pregnant woman, and make her feel accepted through enhancing her self-esteem, health and emotional wellbeing, thus enabling her to make appropriate social adjustments.

1.3.6 **Mixed Methodologies and the Research Design**

Qualitative and quantitative research designs were used by way of methodological triangulation. Triangulation was further achieved through the use of multiple data sources. Qualitative and quantitative methods were used to complement each other. The qualitative method was used as preliminary to the quantitative method. An interpretive qualitative approach, as described by Merriam and Associates (2002), was used to validate quantitative data by providing a different perspective on psychosocial risk assessment by midwives during antenatal care (Pope and Mays 2000). The following methodologies will be further described within the methodology chapter.

1.3.6.1 **A case study approach**

The phenomenon within this study context is psychosocial risk assessment and psychosocial support during antenatal care. The unit of analysis is the midwives and the pregnant women's experiences of psychosocial risk assessment, and the educational records for midwifery education. An exploratory, descriptive and contextual design is used in order to understand the unique dynamic and holistic perception of psychosocial support by midwives and pregnant women. A case study is a bounded and integrated system, based on an intensive description and analysis of a phenomenon or social unit (Merriam, 2002) and as such, was used to establish the perception of psychosocial risk assessment by midwives during antenatal care, and the pregnant women's perception of psychosocial support during pregnancy.

1.3.6.2 **A cross-sectional survey**

Three cross-sectional surveys were conducted to establish:

- The existence of stressful events in pregnant women which were explored through a self administered questionnaire;
- The review of the women's antenatal cards by the researcher for a reflection of psychosocial care.
- The perception of psychosocial assessment and care by use of a self-administered questionnaire distributedto midwives at the Annual Congress of Midwives of South Africa in 2009.

1.3.6.3 **Retrospective record review**

The following records/documents were reviewed to establish the extent of psychosocial care content:

- Midwifery education and training records and the Midwifery education curriculum from three Nursing Colleges in Gauteng Province
- The South African Nursing Council (SANC) Midwifery curriculum and regulations

1.3.6.4 **Constant comparative theory**

The analytic procedures prescribed by grounded theory were built within the case study in order to ensure that analysis was interactive based on Merriam (2002)'s perception that the focus of grounded theory is social interaction as social meaning arises from social interaction with others over time and is embedded socially, historically, culturally and contextually.

A constant comparison method was applied for data analysis through moving back and forth between data collection and data analysis (Charmaz, 2009; LoBiondo-Wood and Haber 2006).

A series of hypotheses were formulated from findings of the data. The final stage of the study was the piloting of guidelines regarding psychosocial risk assessment and psychosocial support during antenatal care.

1.4 THE STUDY PHASES

Figure 1.1 illustrates six major phases in this study, beginning from data collection until report writing.

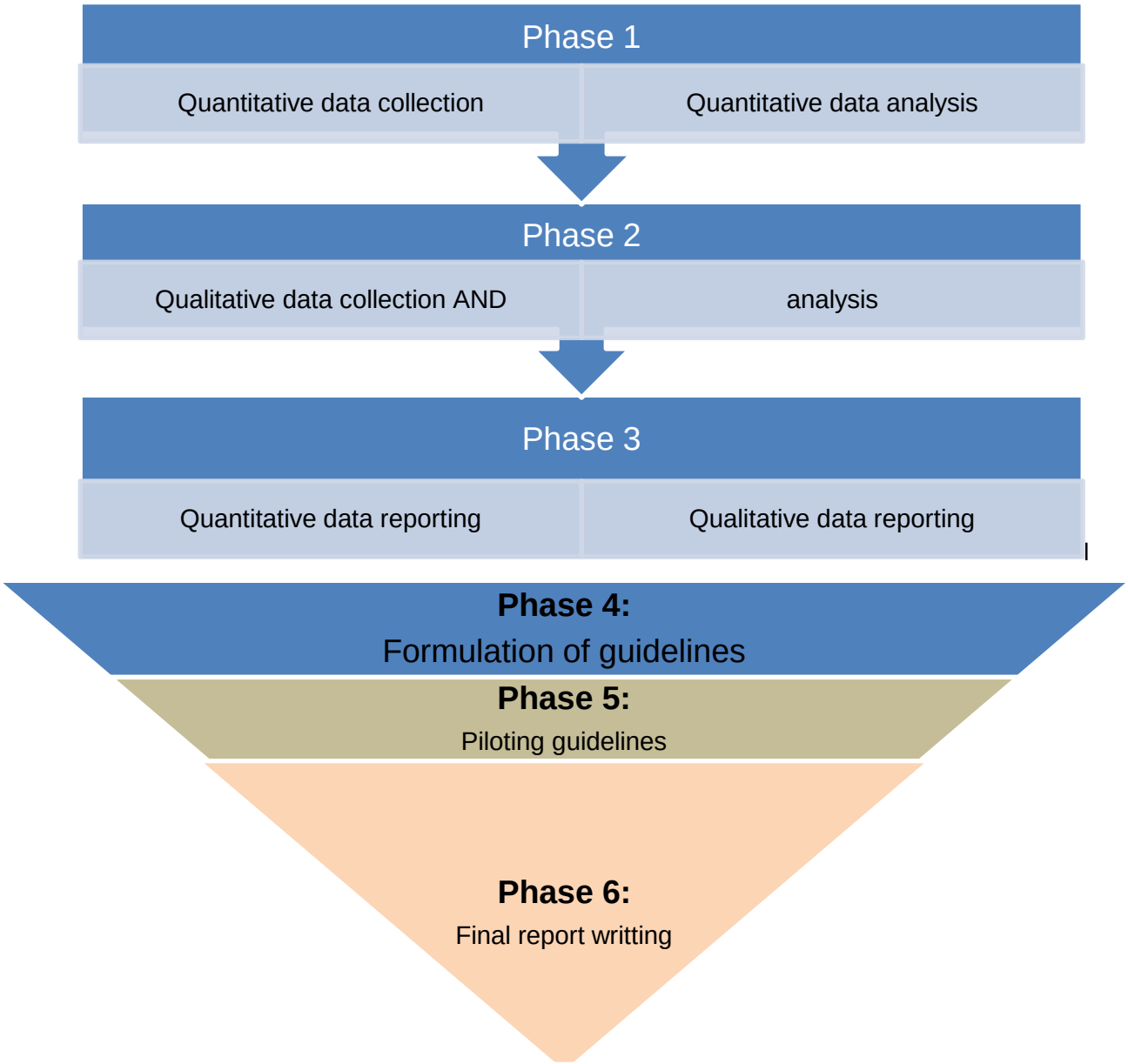

Figure 1.1: Study Phases

1.5 THE STUDY COMPONENTS AND SAMPLING

This included midwives in clinical practice, pregnant women attending antenatal care, midwifery education curriculum, tests and examination papers, clinical assessment tools, antenatal care cards, the South African Nursing Council midwifery regulations and midwifery experts (Appendix G). Sampling was purposive for all data sources.

1.6 RESEARCH QUESTIONS

The study was designed to answer the following mixed methods questions.

Quantitative questions

- To what extent is psychosocial care included within the South African Nursing Council Midwifery training curriculum?
- Do the Gauteng Provincial Antenatal Care Policy guidelines include psychosocial risk assessment and psychosocial care during antenatal care?
- Are midwifery students theoretically and clinically instructed about psychosocial assessment and psychosocial care?
- Are midwifery students theoretically and clinically assessed on psychosocial risk assessment and psychosocial support during antenatal care?
- To what extent do pregnant women present with psychosocial risk factors during antenatal care?
- Do midwives conduct psychosocial risk assessments during antenatal care?
- Do midwives provide psychosocial support during antenatal care?

Qualitative questions

- What are the perceptions of midwives regarding psychosocial risk assessment and psychosocial support during antenatal care?
- What are the experiences of pregnant women regarding psychosocial assessment and the psychosocial support offered by midwives during pregnancy?
- Do midwifery experts consider psychosocial risk assessment and psychosocial support an important aspect of the management of women during antenatal care?
- What are the perceptions of midwifery experts regarding the content and quality of psychosocial care within midwifery training in South Africa?
- What are the perceptions of midwifery experts regarding the psychosocial management of pregnant women?

These questions are linked to the study objectives and will be addressed through quantitative and qualitative data collection methods that are described under the methodology chapter.

1.7 DATA COLLECTION

Phase1: datacollectionoccurred through a sequence of steps that are displayed in Figure 1.2

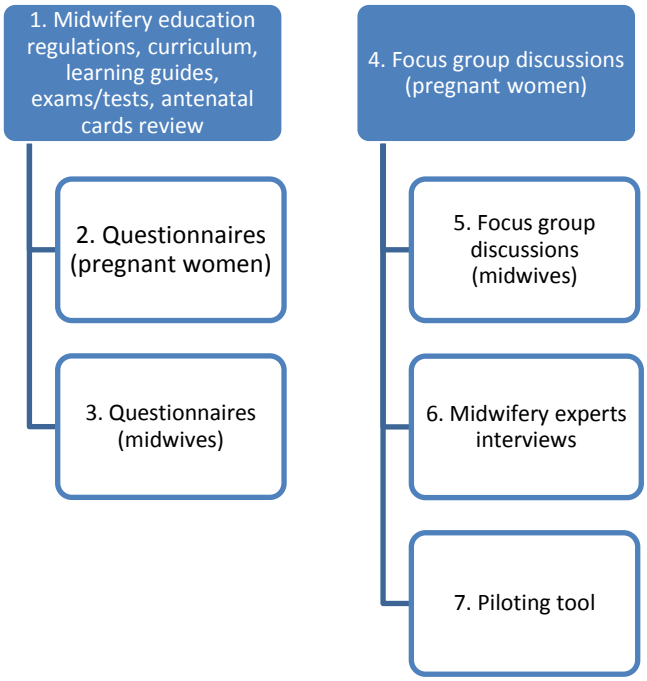

Figure 1.2: Sequence of Data Collection

1.8 PSYCHOSOCIAL THEMES

The following general themes werethe focus of data collection, as reflected in the questionnaires, document review or through interviews.

- The pregnant woman's social functioning and sources of psychosocial support, for example family, community or religion.
- The type of care that is given during the first and subsequent antenatal visits.
- Type of support given to the woman during pregnancy.
- Stressful life events for example, death of a loved one.
- Substance abuse by woman or partner.

- Existing obstetric and medical conditions.
- Past obstetric history, for example foetal losses, separation, family violence etc.
- Availability of resources for psychosocial support.
- Whether, in the participant's opinion, the type of care offered is appropriate and adequate.
- The inclusion of psychosocial content within midwifery education and training.
- The perception of midwives regarding psychosocial care during childbirth.

1.9 CONCLUSION

The process of adapting to pregnancy and the resulting life changes is often difficult, even if the pregnancy is planned. Pregnancy involves intense emotional, spiritual, psychological and social factors that need a midwife's caring awareness and responsiveness. A pregnant woman should recognize and incorporate these changes into her self-image, her social network and her lifestyle. When the pregnancy is unplanned, the psychosocial changes may be more profound and lead to uncertainty, anxiety and depression (Handley, 2006).

In summary, there is a growing need for understanding the place and significance of maternal psychology and other psychosocial factors in the management of pregnant women by midwives. This is evidenced by the possible effects of maternal stress on the outcome of pregnancy as cited in literature. Strategies for supporting maternal and foetal mental health need to be developed, as the importance of good quality pregnancy extends beyond antenatal care. Psychosocial risk assessment during pregnancy is considered as the first strategy to support maternal wellbeing as this will allow the pregnant woman to cope with her pregnancy (Coussons-Read,Okun and Nettles, 2007).

CHAPTER 2

2. PHILOSOPHICAL PERSPECTIVES FOR THE STUDY

Chapter two discusses the philosophical perspectives for the study. It provides a variety of philosophical viewpoints on holistic and comprehensive antenatal care, a feminist standpoint, critical theory, pragmatism and woman-centered antenatal care. Three historical Nursing theorists' views regarding holistic care are shared within this chapter.

Philosophically, mixed-methods is based on philosophical and methodological pragmatism and a very broad and inclusive ontological realism which includes subjective, inter-subjective and objective realism (Onwuegbuzie et al, 2006).

The need for a holistic approach to health care and a comprehensive health care assessment are the researcher's philosophical assumptions. Pragmatism, Feminism and Critical theory formed the philosophical basis for this study.

2.1 THE PSYCHOSOCIAL PERSPECTIVE OF ANTENATAL CARE

2.1.1 Antenatal Care: The Psychosocial Control of Women

Historically and contemporarily, much of what constitutes antenatal care throughout the world remains strongly rooted in the medical model within which it developed. Widespread, institutionalized routine antenatal care began around eighty years ago, focusing on mass screening with the aim of reducing maternal and perinatal morbidity and mortality under medical supervision (Clinical Guideline, 2003). What is of concern within the context of antenatal care are the beliefs and assumptions that continue to underpin the structure and content of antenatal care.

Traditionally, antenatal care consists of a prescribed set of acts with a focus on the clinical physiological monitoring and screening of pregnant women. This approach was based on the notion by Oakley (1984)that pregnancy is a state of pathology rather than a normal physiological and developmental stage (National Collaborating Centre for Women's and Children's Health Commissioned by the Clinical Guideline, 2003).

Irrespective of how maternity care providers perceive antenatal care, the important issue to be taken into consideration is the woman. From a psychosocial point of view, for midwives using a midwifery model, antenatal care is a time of building a relationship with each woman and her family. It is a time when a partnership is developed and negotiated, expectations, roles and

responsibilities are identified, options are discussed and choices are made by women and supported by midwives.

While not neglecting physical safety, antenatal care should be emotionally, socially, culturally and religiously acceptable to the woman. Physical care alone is not sufficient for the woman, as her needs and expectations are different from those of the provider. The effectiveness of antenatal care as a central focus is still being discussed by midwives, obstetricians, medical anthropologists, sociologists and women's organizations. Oakley (1984) in her book "Captured womb" wrote extensively on pregnancy, antenatal care and childbirth. She argues the importance of antenatal care, but also believes that antenatal care is something that is done in an attempt to controlthe behavior of women's bodies, an intervention done to women which does not benefit all women, but probably a few who do not know what to expect from an antenatal care service.

Oakley's 1984 critique is supported by other women and women researchers (Browner and Press, 1996; Cartwright, 1979a; Corea, 1985; Donnelly, 1992; Lazarus, 1997; Riessman, 1983; Rothman, 1986; Vincent-Priya, 1991; Winter, 1988).These authors based their views and criticism on their own experiences and research. Oakley's criticism is related to the medicalization of childbirth where there is limited control by women of their own care. As a result of this medicalization of pregnancy, a parallel shift from unmedicated pregnancies, home births and midwifery-conducted deliveries to pregnancy maintained through technology, obstetrician-led hospital births and increased rates of caesarean section occurred.

Purdy, 2001(as cited by Delwo, 2010) defines medicalization as the process that transpires when health practitioners treat natural bodily functions as if they are diseased. Purdy further stated that it is essential that conventional medicine re-evaluatesits health care model towards the needs of patients and not itsown.

Conventional medicine must also accept other health care practices such as midwifery-led maternity care as a valid source of health, especially to address psychosocial risk factors. Women's health problems, including pregnancy, should cease to be medicalized.

Parry (2008) in a study exploringwhether Canadian women's choice of midwifery care identifies a resistance to the medicalization of pregnancy and childbirth,came to theconclusion that women have a desire for personal control of their pregnancy as reflected in this comment:

"*I just wanted to be in control of what was going on with my body, It scares me that they will push you when you are in your most vulnerable state, because it is more convenient for their schedule".* Participants further related how midwifery care met their needs for control over their bodies, their pregnancies and their experiences with childbirth, notwithstanding a sentiment that medical interventions also have a place in pregnancy and childbirth.

An ideal option for effective antenatal care is the incorporation of psychosocial care as a component of antenatal care, acknowledging the women's own experiences of pregnancy. Midwifery, which means "to be with women", is based upon a philosophy of care in which the management of pregnancy is shared between the midwife and the woman, with a focus on informed choice, shared responsibility, mutual decision-making and women articulating their health needs.

2.1.2 **Antenatal Care: A Technical Problem for a Financial Gain**

An ideology espoused by Jones (1998) is that technology is irreversibly embedded in health care delivery systems. Midwifery, as part of nursing, is conducted in a technological world. Midwives have no choice but to use technology. This technology, to a certain extent, inhibits the midwife-woman relationship. The already existing gap between nursing theory and nursing practice, compounded by the use of technology, poses a challenge to holistic care for a childbearing woman. This ideology is evidenced by the researcher's informally observed current midwifery practice of a complete reliance by midwives on the use of cardiotocography (CTG) to manage a woman who is experiencing labour. The historical manual assessment and management of a woman during labour, which integrated supportive care, seems to be gradually fading away.

The expanding childbirth industry perpetuates a focus on the physiology of pregnancy. Women are exposed to a limited choice of birthing options as reflected in the rising caesarean section rate. Haaf (2005)states that women's informed choice as an important aspect of psychosocial care, is often overlooked. A study by Parry (2008), exploring the use of midwifery-led care by women, revealed that medical interventions have a place in pregnancy and childbirth to address medical and obstetrical complications, although most of the time they are not necessary.

The ideology was better summed up by Inhorn (2006) who stated that “The technological excesses of biomedicine in the face of ongoing medicalization require constant surveillance and vigilance to prevent unnecessary medical control over women’s lives”.

2.1.3 **Antenatal Care: A Way to Reduce Morbidity and Mortality**

Psychosocial care during pregnancy should be viewed as a factor in reducing maternal morbidity and mortality as according to Dragonas et al(1998), a number of correlational studies have indicated that psychosocial factors during pregnancy are associated with an increased risk of physical complications, which might result in maternal morbidity and mortality.

Within the South African context, maternal mortality is said to have escalated from 150-200 per 100 000 live births in 1996 to 600 per 100 000 live births in 2007 (Human Rights Watch, Odhiambo, 2011). There is little evidence for psychosocial care as an intervention to reduce maternal morbidity and mortality. The main factor, as identified by Willinck etal (2000), is for maternity providers to prioritise psychosocial assessment and care, and evaluate its impact on maternal morbidity and mortality.

Another important outcome of antenatal care, apart from reducing morbidity and mortality, is its ability to reduce anxiety in expectant women, offering women a sense of control (Oakley, 1992) and reducing use of pharmacological pain relief during labour, thereby offering women greater satisfaction with antenatal, intrapartal and postnatal care. For antenatal care to be effective in reducing maternal and foetal morbidity and mortality, a shift in focus should be directed to psychosocial care as some literature reports an increased incidence of mortality related to lack of psychosocial care. In some instances this is even higher than mortality caused by medical or obstetrical conditions (Willinck et al, 2000).

As stated in the National Institute for Clinical Excellence Guidelines (2003) and other literature for exampleHall(2001 as cited in the Guidelines, 2003), the procedures that are commonly undertaken to monitor pregnancy are aimed at reducing morbidity and mortality, but have been found to often cause physical, social and emotional harm. The physiological care that is routinely offered during antenatal care, for example physical examination, abdominal examination, monitoring of blood pressure, urinalysis, blood investigations and tests such as ultrasonography, clearly illustrate that the scope of antenatal care is primarily derived from a medical perspective. The implication is that routine antenatal care fails to meet reasonable expectations and the needs of women.

2.2 HOLISIM IN ANTENATAL CARE

2.2.1 What does Holism Entail?

Holism, as explained by Patterson (1998), implies that “the whole is greater than the sum of its parts”. A holistic ideology is ideal for all health care practitioners. According to the American Holistic Nurses Association (AHNA, 2001), nursing has been embracing holism to a varying degree throughout its history. Holistic nursing should be practiced by nurses in every area of care. Holistic care as a speciality is based on a practice that recognizes the body-mind-spiritual connection of a person and commands its practitioners to integrate self-care and self-responsibility into their own lives for them to be able to manage women holistically. A health care practitioner who believes in holism often considers and offers complementary and alternative forms of health care as options (Tierney, 2006).

Holistic health is multidimensional health care, characterized by an assessment of all determinants of health, and considering each patient or client as a whole person. A holistic approach to nursing care is based on ancient beliefs that the spirit is as legitimate a focus for nursing care as the body (Brooker and Waugh, 2007).

The focus of holism on health is preventive with a belief in the body’s own healing process, which can be achieved through the provision of health information. If a midwife believes that pregnant women are responsible for their own health care, she will engage with them in managing their pregnancies. The main aim for a holistic approach is to achieve an optimum level of wellbeing, which is desirable for managing a pregnant woman. In holism, a health care provider is a facilitator and teacher, with an additional ability to assess and interpret symptoms that are deviant from normal health. This is in keeping with the focus of this study which is psychosocial risk assessment during antenatal care.

Although the World Health Organization’s constitution (1948) defines health as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity”, it has been widely criticized (Brooker et al, 2007) for the concepts “state” and “complete”, with the former not fitting with a modern view that health is dynamic, and the latter being unrealistic and unattainable, WHO nevertheless, provides a holistic definition of health as it includes the physiological and psychosocial aspects of health, which is ideal for pregnant women.

Based on various definitions of holism by various philosophers, holism address five dimensions of a woman's health,as reflected in Figure 2.1.

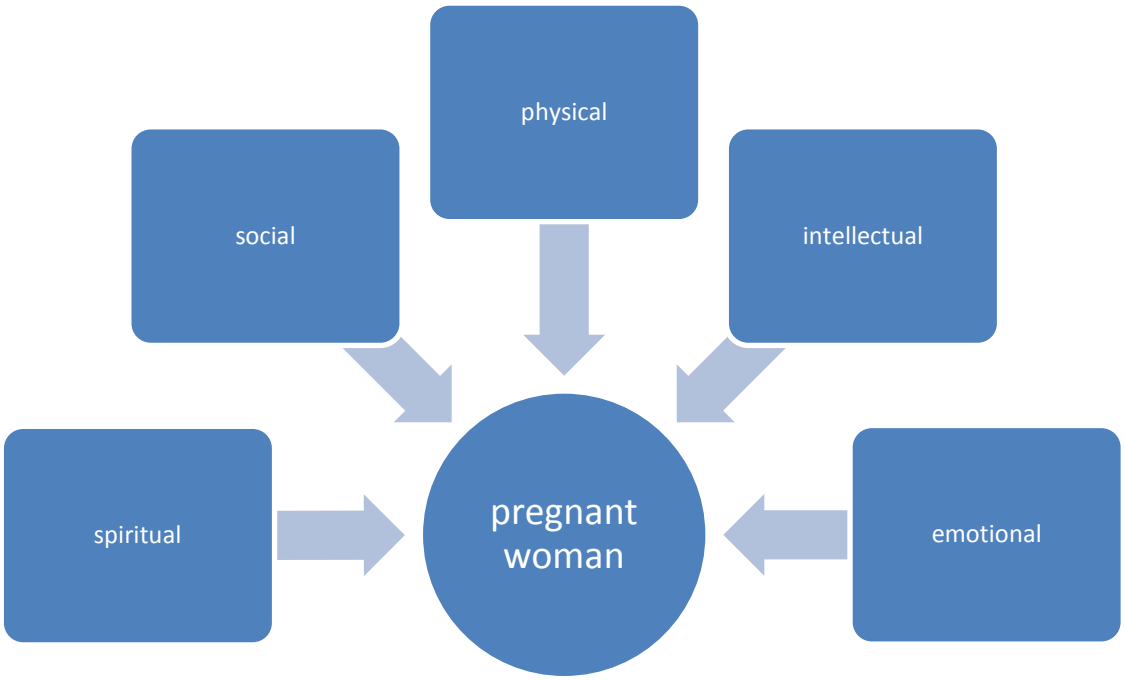

Figure 2.1: The Dimensions of Holistic Care for a Pregnant Woman

The holistic approach recognizes that all parts of a person are significant, taking into consideration how these parts can work together to help the whole person. A holistic philosophy, as applied to antenatal care, involves a focus on the whole pregnant woman. It emphasizes the connection of her body, mind, spirit, emotions and social position.

A study by Parry (2008) of women's perceptions of antenatal care revealed the women's need for holistic care, based on participants' responses: for example *"with midwifery you are treated as a whole person, not simply a pregnancy. If midwives have to deal with only one aspect of the woman, which is physical care, we are left with an incomplete view of the woman, which will lead to an incomplete management of her pregnancy.* Within the context of this study, holism also involves the midwife and the woman as two separate parts, becoming one whole when the two manage the pregnancy together.

Holistic health aims to achieve maximum wellbeing. As such, women should accept responsibility for their own level of wellbeing, which can be achieved through informed choices. Holistic healthy lifestyle is regaining popularity as holistic principles offer practical options for achieving a high level of vitality and wellbeing (Walter, 1999).

Walter further argues that a holistic approach to healing goes beyond just the elimination of symptoms, but treats the cause as the irritation in the form of a symptom which will be suppressed while the real problem is overlooked. This argument is likened to psychosocial risks during pregnancy that often lead to psychosomatic illness. If clinicians address the physical condition without using a holistic approach to establish the root of the problem, an ideal level of wellness for the woman will not be achieved.

Holistic care is reflected as a key concept within the South African Nursing Council (SANC) regulations and the Midwifery Curriculum which form the basis for Midwifery Education and as such, Midwifery Practice. The effect of SANC's choice of holism as a philosophy, is to direct nurses and midwives to apply a holistic approach that looks at how the woman's parts work together, rather than looking at each part in isolation. The focus should be on the whole organism or whole system. It is an approach that incorporates the interrelationships between all aspects of bodily functions and psychosocial functions. Holism, as such, emphasizes the importance of understanding a person's whole being, rather than breaking down, studying or treating only the component parts (Tjale, 2007).

2.2.2 **Holistic Midwifery Care**

With reference to the 2001 American Holistic Nurses Association's description of Holistic Nursing, holistic midwifery care relates to the identification by a midwife of the interrelationship of the bio-psycho-socio-spiritual dimensions of a pregnant woman and understanding the woman as a unitary whole in a mutual process with her environment.

For AHNA, practicing holistic nursing requires midwives to integrate self-care, self-responsibility, spirituality and reflection on their lives, which will make the midwife interconnect with self, others, nature and God. This awareness may further enhance the midwife's understanding of each woman as an individual. The core values of holistic care, which provide a basis for holistic practice, as reflected in the standards for Holistic care by AHNA, are applied within the context of this study, as reflected in Table 2.1.

Table 2.1: The Core Values of Holistic Midwifery Care *(Adapted from AHNA, 2001)*

Core value	Midwifery context
Philosophy and education	Incorporation of a philosophical framework for holistic care into midwifery education
Holistic ethics	Midwifery theory and research to be bound by ethical principles that embrace holistic care
Holistic nurse self care	Midwives to engage in self-care to promote health and personal awareness so that they can serve women as instruments of healing
Holistic communication	Midwives to engage with women to determine mutually-determined plans to manage the woman's pregnancy
Holistic caring practice	Midwives to assess and manage women holistically, specifically during antenatal care. Practice should be based on knowledge, expertise, intuition, creativity and critical thinking

Based on a holistic perspective, an ideal midwife should acknowledge and support the woman's decisions, cultural and spiritual beliefs, family system, and provide her with information and counseling services based on her needs.

2.2.3 Are Nursing Theories Holistic?

This is a question that was posed by Hancock (2000) and Jones (2008), in a debate on holism. Their argument was that nursing's claim to be holistic is paradoxical, probably based on failure to integrate theory and practice in nursing. Hancock viewed holism in nursing as just etiquette, as theoretically some of the nursing theorists are holistic. The identified theorists who are commonly referred to in nursing and who had a holistic viewpoint are Virginia Henderson, Florence Nightingale and Abraham Maslow.

2.2.3.1 Virginia Henderson: fourteen (14) basic needs theory

Atheorist and a philosopher who lived between 1897 and 1996. Henderson's metaparadigm of nursing reflected the importance of psychosocial care. Her viewpoint regarding nursing was that "*The unique function of a nurse is to assist an individual, sick or well, with the performance of activities contributing to health or its recovery. She will perform unaided if she has the necessary strength, will and knowledge, and do this in such a way as to help her gain independence"*(Hall, 2011).

Within Henderson's definition of nursing, a pregnant woman is considered well if classified under the heading low risk, and isa woman who needs assistance from a midwife to manage her pregnancy. She emphasized that the care given should empower the woman to gain independence in self care. A nurse, according to Henderson, should be knowledgeable in both

biological and social sciences, and must have an ability to assess basic needs from the physiological and social perspectives.

Henderson defined a person as consisting of the mind and body which are inseparable, as well as an emotional aspect, an individual who needs assistance to achieve health and independence which is applicable to women during antenatal care. She viewed health as a multifactorial phenomenon that requires independence and interdependence. Within the context of this study, a pregnant woman requires some independence to manage her pregnancy. Interdependence is reflected within a relationship between the woman and a midwife as the woman is dependent on the midwife for midwifery care and the midwife also depends on the woman for information pertaining to her social, emotional status, her experiences and expectations of her pregnancy.

Henderson's fourteen basic needs offer a holistic approach of care which is paramount to the management of a woman during childbirth. Note Figure 2.2.

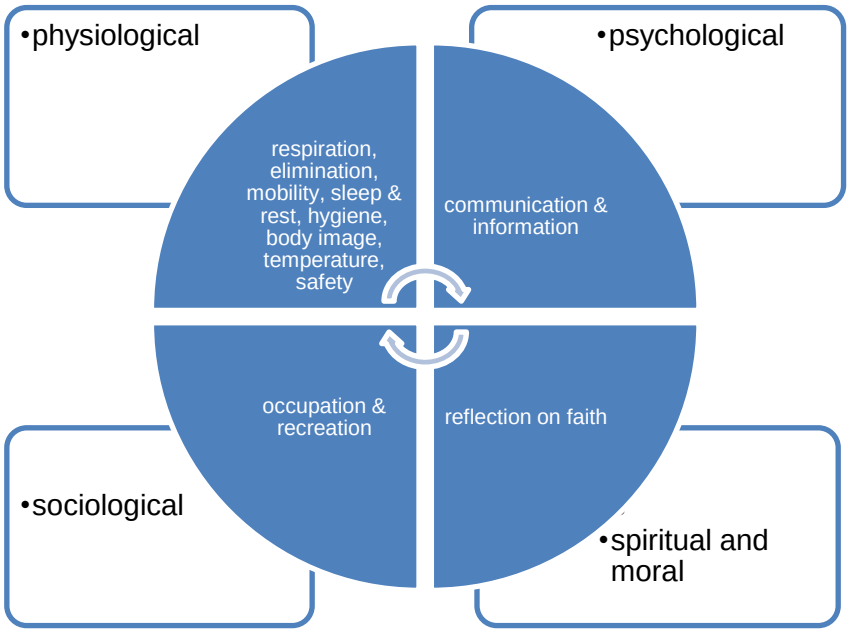

Figure 2.2: A Schematic Representation of Virginia Henderson's Basic Needs

The nurse-patient relationship is based on partnership. The midwife and a woman should have a mutual agreement on the plan of care. The midwife acts as an advocate for the woman as well as a resource person. She should empower the woman to enable her to make informed

decisions. The midwife is seen as a member of a health care team who coordinates the care of the woman and refers her accordingly.

2.2.3.2 **Florence Nightingale's holistic philosophy**

Florence Nightingale, a pragmatist, lived at a time when allopathy and homeopathy were competing for dominance in medical care. Her philosophy of health and healing was closer to the holistic philosophy of homeopathy than to the mechanistic philosophy of allopathy. Nursing can reconnect with Nightingale's holistic philosophy by preparing nursing students in a holistic philosophy; the same principle of a holistic curriculum applies to Midwifery education (Light, 1997).

2.2.3.3 **Maslow's hierachy of needs**

Abraham Maslow (1943), in his Hierachy of Needs, based his self-actualisation counselling model on a holistic view of man, where man cannot be studied or viewed piecemeal, but a being in whom all aspects of his personality are closely interwoven (Elleanor and Ross, 2009). Based on Maslow's needs, a pregnant woman should be viewed as an individual with general and specific needs, rather than a physical being.

2.3 **PRAGMATISM**

Pragmatists, for example, Charles Sanders Peirce and James Dewey (Johnson and Onwuegbuzie, 2004), advocate for the use of both quantitative and qualitative methods in a single study. Pragmatism is appropriate for the research questions of this study as it focuses on the use of diverse approaches, and values both objective and subjective knowledge (Hanson et al, 2005). Pragmatism is used to determine the meaning of concepts, words, ideas and beliefs, and to clarify the consequences of action taken. It sheds light on which action to take next in order to get a better understanding of the phenomenon, and guides on how the research approaches can be mixed fruitfully.

Within this study, pragmatism was applied through the use of quantitative and qualitative methods to obtain objective and subjective data regarding psychosocial care.

2.4 FEMINIST STANDPOINT

Feminism is basically viewed as a theory that men and women should be politically, socially and economically equal (Gramstad, 2000). Feminism, within the context of this study, is based on its definition byRyan 1992(as cited by Gramstad 2000) as “women being associated with other women to create a better world overall, but especially a better space for women”. Furthermore, Casselman (2008) refers to feminism as “a policy, practice or advocacy of political, economic and social equality for women.” He further highlights that a feminist is a person who advocates women’s rights. These definitions reflect on the feminist role of midwives offering antenatal care to pregnant women, and the advocacy role of the researcher by conducting a study on psychosocial care.

The qualitative part of the study was based on the principles of feminist theory through interview discussions held with midwives and pregnant women, which fostered a dynamic interplay between the researcher, the midwives and pregnant women. Feminism has been widely defined from a political, social and health care perspective. As stated by Woliver (2002), the feminist standpoint theory is focused on uncovering assumptions about power differentials within a patriarchal society. Knowledge, which pregnant women seek regarding the management of pregnancy, is one of the key components of power. Feminist theorists are of the opinion that knowledge should be grounded from the lived experiences of women; as applied to this study the experiences were canvassed through focus group discussions held with both midwives and pregnant women.

Casselman (2008), in her book that addresses the grassroots of feminism, refers to feminism as “a policy, practice or advocacy of political, economic and social equality for women.” She further highlights that a feminist is a person who advocates women’s rights, and that the goal of feminism is to ensure that women understand their position and develop knowledge and power. This goal pertains to the position of antenatal care within the context of this study, which should allow women mutual participation in the management of their pregnancies,provides health information and consider informed choices.

The subject of feminism is women, and the substance of feminism is the political, psychosocial, spiritual and experiential expression of the woman and her intellectual power. Feminism is about women for women, which is applicable to the female dominated discipline of nursing. Feminism is for all women, and philosophically is a solution to patriarchal structural divisions between males and females. The overall goal of feminism is that women should understand

their position, develop their knowledge and power, and influence and create a culture of positive social and human evolution.

The advocacy role of feminism was applied to this study. The midwife was considered a feminist as most midwives are females, who has a role to advocate for pregnant women. The fact that intimate partner violence during pregnancy is cited as a possible psychosocial risk, and the existence of gender inequality warrant a feminist approach in managing pregnant women. The goal of addressing feminism within this study is to design and implement a comprehensive assessment tool for pregnant women. The principles of feminism, as defined by Casselman (2008), were applied to this study. A captured essence of feminism has been summarized in Table 2.2.

Table 2.2: Feminism as Applied to Both Pregnant Women and the Midwives

Principle	Midwives	Pregnant women
A source of power and strength	Assist midwives to conduct antenatal care with stability and control with reference to the Midwifery Scope of Practice (R2598 of 1984….as amended)	Helps a woman to uncover the unknown about pregnancy and childbirth.
An angle	Opens up a new world of thought by redirecting midwives from the traditional or routine antenatal care to care that includes the social perspective	Offers women an opportunity to discover alternatives and solutions to social challenges that they experience during pregnancy, based on being well informed by midwives
A matrix	Midwives making informed decisions regarding the psychosocial status of women in their care, by committing to change in approach	Women making informed choices about the management of their pregnancies
A tool	A guiding tool to advocate for women	A dispensable tool to wield against gender related psychosocial problems

(Casselman, 2008)

2.5 CRITICAL THEORY AND HERMENEUTICS

According to Merriam and Associates (2002), the world view of critical theory is that man is interpretive and constitutes his world; knowledge is contextually-bound and value-attached, and culture and lay interpretations are involved in searching for perception. Critical qualitative research uncovers, examines and critiques the social, historical, psychological and cultural assumptions of a phenomenon that limits ways of thinking and acting.Habermas (1970), who is

considered one of the main critical theorists, developed theories which were built on a typology of interest as cited by Dash (2005). The three types of interests as illustrated by Dash were:

- The control of the physical environment that generates empirical knowledge.
- An interest in understanding the meaning of a situation, that generates historical and hermeneutic knowledge; and
- An emancipating interest which generates critical knowledge and is concerned with exposing conditions of constraints and domination.

Confirming with Habermas' theory, the aim of this study was to establish a relationship between the theory of midwifery education and training, and the extent of the application of that theory to practice, to evaluate the order of practice, whether value-attached or not.Hermeneutics, within this study, addressed the critical acquisition of knowledge by interpreting the meaning of the experiences for those who were studied.

2.6 A WOMAN-CENTERED PHILOSOPHY OF ANTENATAL CARE

A report on a project that explored women-centered care in maternity at La Trobe University(Health Issues Centre, 2006), stated that theterms "woman-centered care" and "patient-centered maternity care" are used interchangeably in literature to describe care that focuses on women receiving care and not on health care providers. In women-centered care midwives should acknowledge women as individuals who differ in their expectations, needs, values and preferences. Every woman should be a partner in the decisions regarding her pregnancy. Informed choice is an integral part of women-centered care (3 Centers collaboration, 2006-2009). Most literature supports the view that women-centered care is one of the most highly-valued dimensions of midwifery (Rodríguez and des Riviėres-Pigeon, 2007).

Woman-centered care is characterized by mutual participation where a woman brings her knowledge of her past and present physical and obstetric wellbeing, her personal, social, emotional, spiritual and cultural realities, and her experiences of pregnancy into the relationship with a midwife. A pregnant woman is viewed as the first health care provider for herself and the baby. The midwife brings her knowledge and expertise regarding the childbearing process, and shares information that will assist the woman in making informed decisions about the management of her pregnancy.

Although a Cochrane Systematic Review reported a broad description and variety of definitions of patient-centered, the following principles, as described in the Health Issues Final Report (2006) were applied within the woman-centered care context:

- Care that considers woman's informed choices;
- Women having control over the management of their pregnancies, and respect for women's preferences;
- Health care providers working in partnership with women, with the key principle being, choice, continuity and control;
- Individualized care and
- Family-centered care, defined as an approach to maternity care that redefines the relationship between women and their families, with information sharing between the midwife, woman and her family being the cornerstone of this principle; a focus on women as people and not a disease.

Hawkins and Knox (2003) andParry (2008) highlighted that midwifery is a form of woman-centered care that recognizes and celebrates the transition to motherhood for women and their families. By the 1970's, women were disenchanted with the medicalization of childbirth which led midwifery to experience a rebirth. During this period, women were said to demand control over their bodies, their experiences of childbirth and the choice of birth attendants. The period was further characterized by rapidly developing technology that emphasized the role of the obstetrician, while also recognizing the role of the midwife by childbearing women.

A Canadian study on medicalization of childbirth by Parry (2008), led to the development of the following eight woman-centered care themes:

- Woman-centered care;
- A natural approach to pregnancy and childbirth;
- Continuity of care;
- Emotional care;
- Personal control;
- Professional competence;
- Family friendly policies, and
- Family friendly practices

The above are all important components of facilitating psychosocial care during childbirth. With regard to woman-centered care, women who participated in this Canadian study did not prefer a blanket approach to care and remarked as follows:

"*I really wanted a focus on me and what you know was best for me"*Parry (2008).

This statement reflects a woman's own belief, her best choice and autonomy, which are central to women-centered care.

Woman-centered care serves to empower women by offering a sense of control over their bodies, a sense of physical and emotional wellness, and preparedness for parenthood. Empowerment is central to the women's movement which includes a woman's health component, which seeks to empower women to be better informed and be assertive consumers of health care (Woliver 2002). Midwifery, with the cooperation of midwives, specifically regarding psychosocial care, can be an important component of the women's movement. Woman-centered care tends to overcome thefetocentric ideology i.e. an approach which focuses more on the fetus than on the mother.

According to the findings of a project in the final report by the Health Issues Centre (2006)on exploring women-centered care in a maternity unit, the three main challenges for the implementation of women-centered care are:

- Limited guidelines regarding how the outcomes for woman-centered care can be achieved;
- The essential components of woman-centered care; and
- Role ambiguity and role conflict between the woman and midwife.

These issues are crucial, as conflicts may lead to inconsistencies in practice and failure to meet the expectations of women. Furthermore, women as the recipients of care should be considered in determining the components of woman-centered care for it to be mutually determined.

The literature search for this project did not find any study that explored women's views regarding woman-centered care. Data available and of value are from studies that addressed women's needs, expectations or evaluation of maternity care. The findings of the project led to a recommendation for a midwifery curriculum that includes a woman-centered care approach, a conceptual framework that include principles of woman-centered care, women's views about the service, the acquisition of communication skills, cultural sensitivity and implementing a multidisciplinary team approach, refer toFigure 2.3.

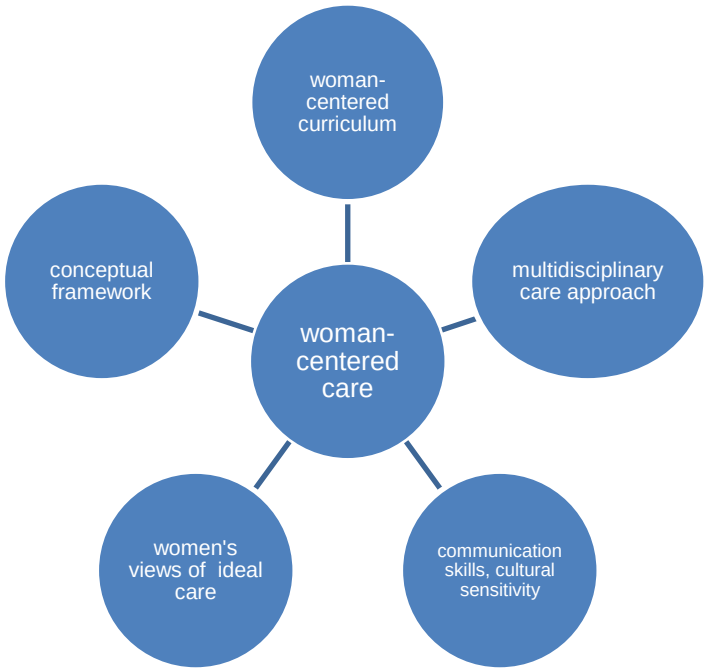

Figure 2.3: Requirements for Implementing Woman-Centered Care

A multivariate analysis conducted by Harriot (2003)as described in the Health Issues Final Report (2006) to determine factors that motivate women to recommend a particular maternity service to others were:

- Being treated with respect, dignity and empathy;
- Women to be given opportunity to offer their opinions;
- To be offered personalized care, reassurance and support;
- Courtesy and availability of staff;
- Confidence and trust in health care providers;
- Women to be involved in decision making;
- Coordination of care through referral; and
- Health information and family involvement;

These are women's views that can only be determined through a reflection on the care that women routinely receive.

The above psychosocial expectations of care are also reflected in previous studies, for example Williamson and Thomson(1996), Thompson(1999), Mathibe-Neke(2008) and

Vanagienė and Vanagasl (2009) whichprovide a starting point for woman-centered care. It is also crucial to ensure that the care offered fulfills the women's needs and expectations, and achieves the objectives and outcomes of antenatal care. It is also important to build the woman's confidence and optimize her independence within her capabilities for woman-centered care to be realized.

The Policy Brief (2010) reflects a global consensus for a woman-centered approach as evidenced by Millennium Development Goal 3 which aims at promoting gender equality and empowering women.

2.7 COMPREHENSIVE HEALTH CARE ASSESSMENT

Comprehensive assessment is the evaluation of physical, developmental, psychosocial, occupational, sexual, cultural and religious aspects or status of an individual through subjective and objective data collection. Comprehensive assessment embraces holism and should be implemented as first-line management of women by midwives during antenatal care. The assessment of a pregnant woman forms part of the "Scope of Practice for Midwives" (R2598 of 1984 as amended) of the South African Nursing Council, and it should be comprehensive in order to address all health care needs of a pregnant woman.

2.8 CONCLUSION

When women's voices are ignored in the construction of knowledge pertaining to pregnancy and childbirth, they become alienated from the experience. Young (2001) explained that women seem to be considered as containers for a developing foetus, as further highlighted by Mitchell (2001) that pregnant women have become "living fetal monitors" (Parry, 2008). The Changing Childbirth Report (2002) explicitly confirmed that women should be the focus of maternity care and that antenatal care should enable a woman to make informed decisions based on her needs.

"The use of the concept "holistic" in the unit philosophy pinned to the office notice board, or the ward day lounge, might currently still be a speech, an act or a promise, but not all promises are kept. This includes the promise made to students who are taught the principles of holistic care in the classroom, only to find that the world of practice continues to impose a task oriented approach in nursing" (Henderson, 2002)

CHAPTER 3

3. THE METHODOLOGY OF THE STUDY

3.1 INTRODUCTION

Chapter three presents the methodology used in the study, the study designs, study population and sampling, the phases of the study, data collection procedures, validity, reliability, trustworthiness and the legitimation process.

3.2 A MIXED- METHOD APPROACH

The methodological approach in this study is a mixed method approach, through combining quantitative and qualitative research techniques, methods and approaches to address psychosocial risk assessment and psychosocial support by midwives during antenatal care (Creswell, Shope, Plano Clark and Green, 2006). Categorically thinking, mixed method research sits in a new “third chair”, with quantitative and qualitative research sitting on either side.

The methodology was aimed at accommodating the diverse population involved in the study, the nature of data being sought and the number of investigations conducted. A fully mixed research approach was implemented interactively through all the stages of the study. A mixed method research, which is referred to as a third research paradigm or a third wave that offers logic and a practical option, involved collecting, analyzing and interpreting quantitative and qualitative data within this study**.**

A basic interpretive and descriptive qualitative approach was used. The qualitative approach was characterized by a search for meaning and understanding of psychosocial care, the researcher being the primary tool of data collection and analysis, application of an inductive strategy and the presentation and rich descriptive discussion of findings.

The logic of mixed methods inquiry, according to Johnson etal (2004), includes the use of inductive reasoning (discovering patterns or theory), deductive reasoning(testing theory and hypotheses) and abduction (uncovering the best possible explanations or understanding of the phenomenon).

3.3 QUALITATIVE VERSUS QUANTITATIVE APPROACH

There are similarities between quantitative and qualitative designs. Both approaches, for example, use empirical observation to address research questions, describe their findings, construct explanatory arguments from their findings and ensure validity and trustworthiness to minimize bias (Johnson and Onwuegbuzie, 2004). The latter authors further highlight that the current research world is becoming increasingly interdisciplinary, complex and dynamic. As such, researchers should have an understanding of multiple methods for them to complement one method with another. Furthermore, using mixed methods offers an opportunity to address the research questions from a wider perspective. It implies putting together insights and procedures from each method to produce a superior product.

Although priority was given to the quantitative approach as quantitative data were collected first, more weighting was given to the qualitative approach as it provided the larger part of the context necessary for the study. The qualitative dominance was based on the nature of the study which is socially inclined, the purpose of the study, the research questions and the multiple data sources. The qualitative approach explored variables and constructs that are unknown, and developed themes that may be used to study an underrepresented population i.e the pregnant women (Creswellet al, 2006). The extent of thematic and cross-case data analysis in the qualitative approach justified its dominance.

3.3.1 The Rationale for Combining Qualitative and Quantitative Approaches

The rationale for using mixed methods for this study was: (a) to obtain a better understanding of psychosocial risk assessment and psychosocial support during antenatal carethrough converging numeric trends from quantitative data with specific details from qualitative data; (b) to develop variables or constructs that need to be addressed in psychosocial risk assessment; (c) to convey the needs of pregnant women, who are probably marginalized; (d) the fact that mixed methods are the most appropriate with psychosocial studies to achieve a balance so that a greater diversity of divergent views is obtained (Crump and Logan, 2008);(e) the representativeness and generalizability of quantitative findings and the in-depth and contextual nature of qualitative findings (Hanson et al, 2005); (f) the combination of qualitative and quantitative questions are best answered through a mixed research approach and; (g) to incorporate the strengths of both quantitative and qualitative approaches and to overcome the weakness of each .

3.4 THE RESEARCH DESIGN

A sequential explanatory design was used in this study.

3.4.1 Sequential Explanatory Design

A sequential explanatory design, which is quantitatively driven and consisting of two distinct phases was used in this study. Quantitative data were collected and analyzed first, followed by qualitative data collection and analysis. The quantitative method focused on hard generalizable data involving a formal writing style using an impersonal passive voice and technical terminology, whereas the qualitative method is based on detailed, richly described observational data that were narrated directly and more informally (Hanson et al, 2005; Collins, Onwuegbuzie and Jiao, 2007).

3.4.1.1 A model for sequential explanatory mixed method design

The following is a graphical representation of the sequential explanatory design for this study, which assists in visualizing the sequence of data collection and connecting and mixing points of the two methods (Ivankova, Creswell and Stick, 2006).

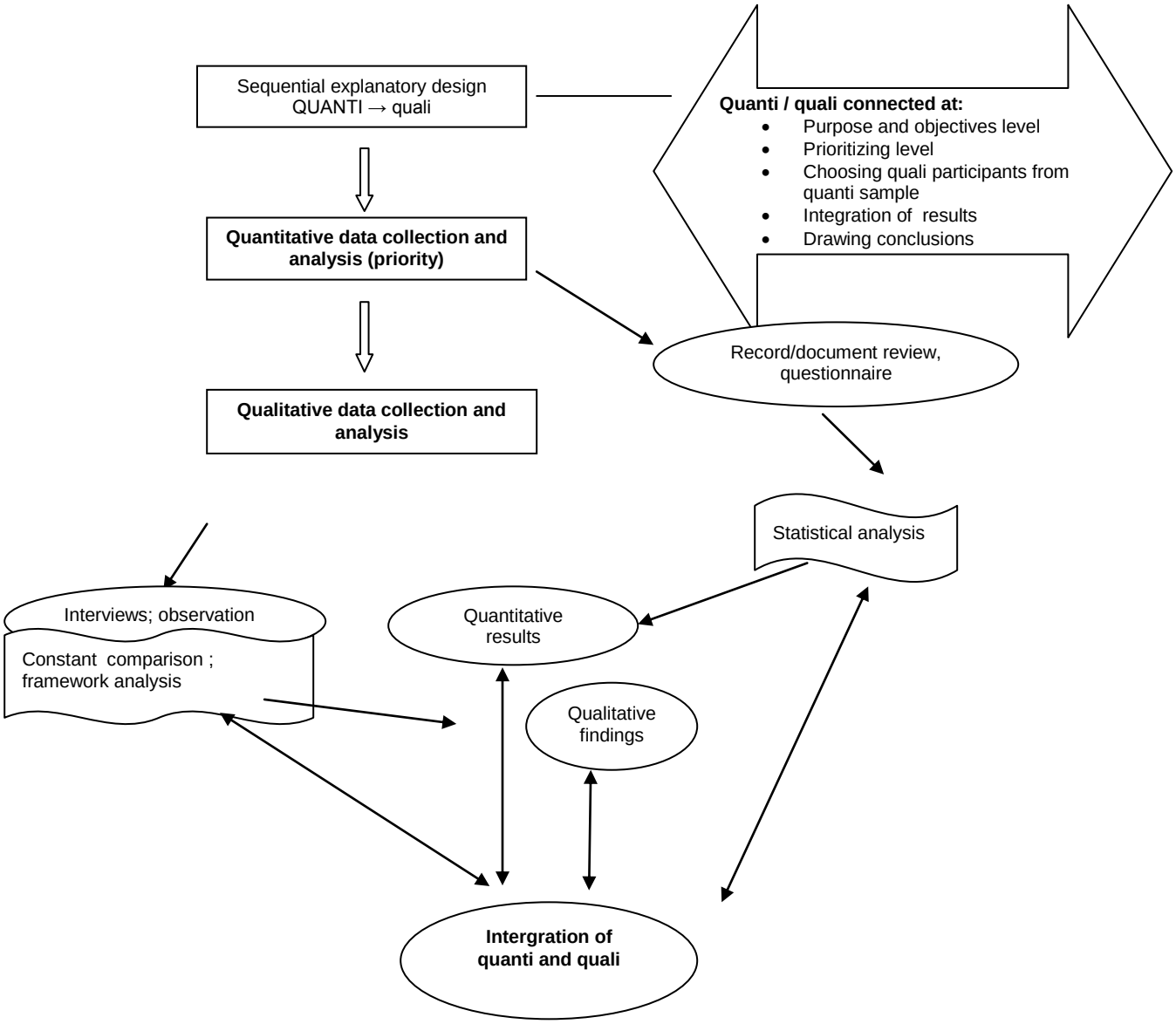

Figure 3.1: The Procedural Notation for a Sequential Explanatory Design

The rationale for a sequential explanatory design is that the analyzed quantitative data provided a general overview and understanding of psychosocial care during pregnancy, the qualitative data and their analysis refined and explained the statistical results by exploring the midwives', midwifery experts' and pregnant women's views at the functional level. The goal of the quantitative phase was to establish the extent of inclusion of psychosocial care in the midwifery education curriculum, and the qualitative phase aimed at exploring the existence of psychosocial problems and to establish if psychosocial assessment and psychosocial support were implemented during antenatal care.

3.4.2 **Research Methods**

Multiple research methods were used in this study. A sequential explanatory process was followed at the research design, data collection and data analysis phases. Data collection was partially concurrent as a midwives' survey was conducted at the same time as focus group interviews.

3.4.2.1 **A cross-sectional survey**

A cross-sectional survey was used to obtain quantitative data. The objectives for using a survey as a non-experimental, descriptive research method, based on Fink's (2003) explanation of a survey, was to establish and describe the psychosocial content of Midwifery education in the curriculum and regulations of the South African Nursing Council; to evaluate whether the South African Nursing Council curriculum and policies have been implemented by the Nursing Colleges that offers Midwifery education in Gauteng Province; to establish the knowledge attitudes and behavior of midwives regarding psychosocial health during pregnancy, and to explore the incorporation of psychosocial risk assessment and psychosocial support during antenatal care. Midwives and women responded to open-ended and closed-ended questionnaire as part of the survey.

3.4.2.2 **A multiple case study design**

A case study methodology was used through an in-depth data collection, description and analysis of detailed and relatively unstructured information regarding psychosocial care during pregnancy. The aim was to describe in detail the phenomenon of psychosocial, involving multiple sources of information including those being studied, and multiple levels of data analysis. The unit of analysis for this study is the midwives' and the pregnant women's experiences of psychosocial risk assessment and psychosocial care (Lo-Biondo-Wood et al, 2006; Ivankova et al, 2006).

The cases that were selected for the follow-up qualitative phase were midwives offering antenatal care service, the pregnant women who attended antenatal care, the midwifery experts, as well as thepilot testing of the formulated guidelines which were used as a means of introducing psychosocial care to the midwives offering antenatal care.

3.4.2.3**The research process model for the study**

The research process model of mixed methods (Creswell, 2003) was adopted for this study. Only aspects applicable to this study have been included in the model.

Alternative knowledge claims			
Postpositivism	**Advocacy**	**Constructivism**	**Pragmatism**
Determination Reductionism Empirical observation and measurement Theory verification	Political Empowerment issue-oriented Change oriented	Understanding Multiple participant meanings Social and historical construction Theory generation	Consequences of actions Problem-centered Pluralistic Real-world practice

↓ ↓ ↓

Strategies of Inquiry / Approaches to Research		
Quantitative	**Qualitative**	**Mixed Methods**
Non- experimental design e.g survey	Case study	Sequential Transformative

↓ ↓ ↓

Procedures and practices for data collection and data analysis		
Quantitative	**Qualitative**	**Mixed Methods**
Predetermined instrument-based questions, document review, observational data, statistical analysis	Interview, observational, audiovisual data Open-ended questions	Open-ended and closed-ended questions Multiple forms of data sources Pre-determined and emerging methods Statistical and text analysis

Figure 3.2: A Model of Procedural Notations for Mixed Methods *(Creswell, 2003)*

3.5 A SUPPORTIVE CONCEPTUAL FRAMEWORK FOR MIXED METHODDESIGN

A supportive framework for a mixed method evaluation developed by Greene, Caracelli and Graham in 1989,was applied to the study. The defining concepts for the framework are triangulation, complementarity, development, initiation and expansion.

3.5.1 Triangulation

Triangulation was applied throughout the study by use of multiple research designs, multiple methods for data gathering, and data analysis procedures for both the quantitative and the qualitative designs. The purpose of the methodological triangulation was to gain a better

understanding of psychosocial risk assessment and psychosocial support during pregnancy from the education and training of midwives, the midwives in clinical practice and pregnant women.

Triangulation served as a major component of mixed methods. It assisted in achieving convergence and corroboration of results from different methods and designs, and as such eliminated the inherent biases common in using only one method. Between methods triangulation occurred whereby open-ended questionnaires were analyzed together with data generated from interviews.

3.5.2 **Complementarity**

Complementarity, (Johnson etal, 2004; Crump et al 2008), aims at seeking elaboration, enhancement, illustration and clarification of results from one method with the results from the other method. The purpose of complementarity for this study was to gain a holistic view of psychosocial risk assessment and psychosocial support during pregnancy. For example, self-administered questionnaires for pregnant women and the review of antenatal cards were conducted interactively, and simultaneously followed by group interviews, informal conversations and the researcher's observation.

Perceptions of psychosocial assessment and care were also established through focus group discussions with midwives, and complemented through a self-administered questionnaire. Quantitative and qualitative results were used to measure overlapping but different aspects of psychosocial care (Crump et al, 2008).

3.5.3 **Development**

Where relevant, the methods were implemented sequentially, for example, quantitative results from self- administered questionnaires for women and the review of antenatal cards were instrumental in refining the interview guide for use in focus group discussions.

3.5.4 **Initiation**

The purpose of initiation was to establish contradictions between the midwifery curriculum and the SANC midwifery regulations, the process of the education and training of midwifery students and the implementation of psychosocial care in midwifery practice. The use of mixed paradigms assisted in discovering inconsistencies and why such inconsistencies existed.

3.5.5 Expansion

Expansion was applied through the integration of the findings and the results of the two methods which occurred at the intermediate level after the analysis of quantitative and qualitative data, and during the presentation, interpretation and discussion of the results.

3.6 DATA COLLECTION

A quantitative-qualitative data collection and analysis sequence was followed. The sequential explanatory approach was maintained through, for example, obtaining information from midwives through a questionnaire and through focus group discussions, and from pregnant women through a questionnaire and focus group discussions, using same populations.

Non-probability purposive sampling was done for all data sources.Informal conversations and regular non-participant observations were conducted with both midwives and pregnant women. The two occurred simultaneously but independently. All data were collected by the researcher.

3.6.1 Sample Selection

3.6.1.1 Quantitative sample selection

Sampling involved purposeful selection of the South African Nursing Council (SANC) midwifery education curriculum, the education records for the three nursing education colleges in Gauteng Province where a Diploma in General nursing course is offered, and the antenatal card records for women attending antenatal care.

3.6.1.2 Qualitative sample selection

A purposeful selection of clinics in Gauteng Province that met the inclusion criteria of being a level 1 clinic offering antenatal care to women was done.

Multilevel sampling was applied (Collins et al, 2007) by selecting women from the same population to participate in both the quantitative and the qualitative phases of the study. Midwifery experts who met the criteria were also purposely selected (see Appendix G for criteria).

3.6.2 Data Sources

The four major sources of data collection used were document analysis, interviews, questionnaires and informal observations. Figure 3.3 outlines the data sources and the population.

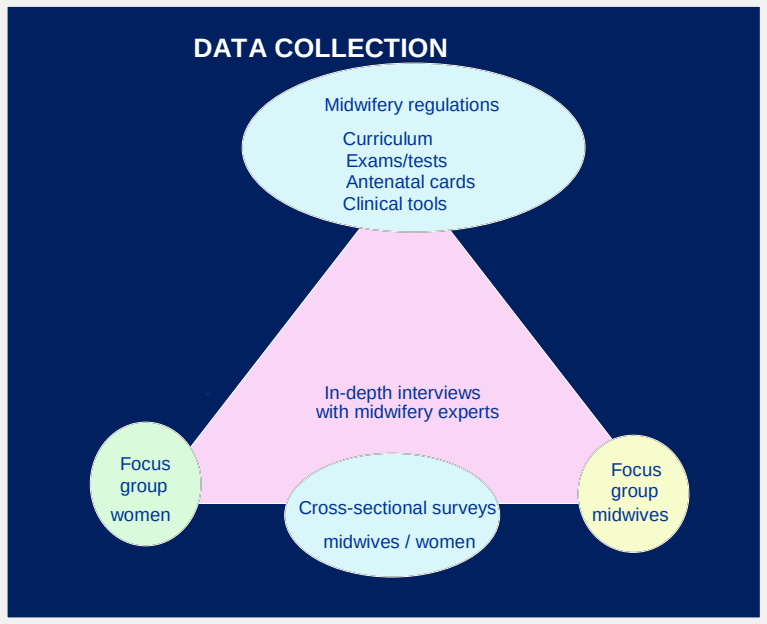

Figure 3.3: A Schematic Presentation of Data Sources

3.7 THE PHASES OF THE STUDY

The study took place in six phases to meet the purpose of this research. Phase 1 entailed quantitative data collection and analysis; phase 2 qualitative data collection and analysis; phase 3 report writing; phase 4 formulation of guidelines; phase 5 pilot test; phase 6 integration of results and findings, and writing of final report. The phases are described in detail under data collection and data analysis.

3.7.1 Phase 1: Quantitative Data Collection and Analysis

Quantitative data were collected from a variety of sources as explained below:

3.7.1.1 Record and document review

Quantitative data were collected through the review of the midwifery education curriculum of the South African Nursing Council (SANC), the review of midwifery curriculum and education and training documents of the three nursing colleges in Gauteng Province, and the review of antenatal cards at the selected clinics.

The South African Nursing Council midwifery education curriculum and Regulations were reviewed. The midwifery Regulations include:

- Regulations relating to the approval of and the minimum requirements for the education and training of a Nurse (General, Psychiatric and Community) and Midwife leading to registration (R.425).
- Regulations for the course for the Diploma in Midwifery for registration as a midwife (R.254).
- Regulations Relating to the Scope of Practice of persons who are registered or enrolled under the Nursing Act, 1978 (R. 2598).
- Regulations relating to the conditions under which registered midwives and enrolled midwives may carry on their profession (R. 2488).

The midwifery test papers and examination papers for the period 2004 to 2009 for the three nurse training colleges in Gauteng province were reviewed to establish if psychosocial issues were theoretically assessed. Clinical accompaniment and assessment tools and the midwifery clinical registerwere reviewed, with the aim of establishing the inclusion of psychosocial aspects of clinical midwifery care. The Gauteng Antenatal Care Policy (1997) was reviewed to establish the inclusion of psychosocial assessment and psychosocial care in the antenatal care program regimen. The guidelines for maternity care which are stipulated in a manual for clinics, community health centresand district hospitals by the Department of Health in South Africa (2007) were also reviewed for inclusion of psychosocial care.

A review of the antenatal cards was done through a non-experimental descriptive, cross-sectional survey method to establish the reflection of psychosocial problems or risks as documented by midwives during antenatal care. A self-administered questionnaire was distributed to pregnant women who visited the three antenatal clinics in Gauteng Province within a six months period (Appendix S). The first review was conducted from February to July 2009, the second from June to November 2009 and the third from September 2009 to February 2010.

The review of these documents and records provided an indication and a general understanding of the extent of the inclusion of psychosocial risk factors within the midwifery curriculum, the extent of psychosocial risk assessment, and the provision of psychosocial support by midwives during antenatal care.

3.7.1.2 **The administration of a questionnaire**

A self-administered questionnaire containing closed and open-ended questions was distributed to pregnant women and to midwives attending the 8th Annual South African Midwifery Congress. Questionnaires for women were administered concurrently with the review of antenatal cards by the researcher at the antenatal clinics.

A general explanation of the questionnaire was given to the participants. Women who struggled to complete the questionnaire, either due to language deficiency or lack of understanding, were assisted by the researcher and the research assistant. Guidelines were given to the women regarding the ideal amount of information to be shared. The translation and interpretation of the questionnaires from Zulu, Tsonga and Venda into English, was done with the help of the assistant researcher.

3.7.2 **Phase 2:Qualitative Data Collection and Analysis**

Qualitative data collection and analysis occurred simultaneously. The researcher explored and described the perception of midwives and midwifery experts regarding psychosocial risk assessment and psychosocial support during antenatal care, and the experience of psychosocial care by women attending antenatal clinics. A series of focus group interviews was conducted with both pregnant women and midwives. The participants were selected purposively based on the criterion that they would have something to share on psychosocial risk assessment and support during pregnancy.

The pregnant women were all of childbearing age and had similar socio-economic characteristics. Midwives were selected based on their experience of offering care to pregnant women. Focus group interviews were chosen as a method data collection because the data generated through social interaction of the group is often richer than can be obtained by means of one-on-one interviews. In addition, focus groups can generate large amounts of data in a relatively short time (Rabiee, 2004). Evidence from other focus group interviews as stated by Krueger (1994) also suggests that participants influence one another through their comments and self disclosure is easy for most of participants. Data were obtained through the recording of the discussions, writing of observational notes, and summarizing the main themes with participants at the end of the interview.

At the beginning of the focus group interview the participants were welcomed and the researcher introduced herself and the assistant researcher to the participants. The assistant

researcher was an individual who was trained in qualitative data collection and conducting focus group discussion. Her main role was to record data during interviews ant to assist in the interpretation of other African languages expressed by participants. The purpose of the study was clarified. Ground rules and guidelines for the interview were explained. Interviews were recorded to capture information that could be missed during note taking.

Participants were advised that:

- Participation would be voluntary and could be terminated at any point;
- There would be no wrong or right answers but differing points of views;
- One did not need to agree with others but needed to listen carefully when others shared their views;
- One needed to respect the views of others;
- One person should speak at a time but participants may talk to each other as a group;
- There should be freedom to share views even if they differ from others. The researcher's role was to guide the conversation, and the assistant's role to take notes and record the responses;
- Mobile phones should be on silent mode and answered quietly (Krueger, 2002).

The qualitative approach, which is exploratory and interpretive, included casual conversations with pregnant women, informal observation of the research setting recorded by the researcher, and the observation of the process of antenatal care as provided by the midwives in the selected antenatal clinics. Focus group interviews were conducted with midwives and pregnant women. In-depth interviews were conducted with midwifery experts.

Priority was given to the quantitative aspect of the study, as the primary objective of the study was to establish the inclusion of psychosocial care in the midwifery education curriculum and the secondary objective was the implementation of psychosocial care in midwifery education and in midwifery clinical practice. A quantitative-qualitative data collection and analysis sequence was followed. The integration of the two methods occurred at the following levels:

- At the study design level through the description of the methodologies and the purpose of using the two methods and the research questions.
- At the intermediate level after the analysis of quantitative data.
- During the presentation of the results; and
- During the interpretation of results, and conclusion.

3.7.2.1 **Focus group discussions with midwives**

Focus group interviews with midwives working at the three antenatal clinics in Gauteng Province were conducted. The midwives were informed about the interviews and given a period of three months to make a decision regarding their voluntary participation. A sample for each focus group was purposely selected from a homogeneous group, i.e midwives working in the antenatal clinic.

The criteria for choosing the sample was that the midwives had similar characteristics as a working group. They were required to have provided care to pregnant women for a minimum of two years in order to be able to share information regarding psychosocial risk assessment and psychosocial support during antenatal care. The researcher, in a focus group, served as an observer, listener, moderator and analyser using an inductive process. An interview guide with open-ended questions was used (Appendix P). Five types of questions were included in the interview guide (Krueger, 2002).

The following questions were addressed:

An opening question:
"Please tell me about your understanding of psychosocial risk assessment during pregnancy"

An introductory question:
"Is it important for you as a midwife to assess a woman psychosocially during pregnancy? Please elaborate, explain further or justify your response"

A transition question:
"Have you ever had an opportunity to assess a woman psychosocially during pregnancy?"
Key questions:
"*Please share your experiences of psychosocial risks during pregnancy, personal or work related; What are the common psychosocial risks that you have encountered during your midwifery practice?; What interventions did you implement if a psychosocial risk has been identified?"*

Ending questions:

"*According to your opinion, should psychosocial support be incorporated within antenatal care? Is there anything that you would like to share regarding psychosocial risk assessment and psychosocial support during antenatal care?"*

Three focus group discussions were conducted with midwives, one group from each participating clinic. Participants were thanked for their contribution at the end of the interview and they were served refreshments as a gesture of gratitude for their willingness to share personal opinions and their involvement in the research study.

3.7.2.2 **The interview setting**

A conducive environment for focus group interviews was provided. The context of the interview was a comfortable room with participants sitting in a circle to promote engagement with each other. The participants were greeted and welcomed. An overview of the purpose of the interview was outlined and ground rules were explained. The participants were invited to relax and engage in exchanging their experiences and feelings.Responses were recorded on an audiotape, transcribed verbatim and analyzed for themes.

3.7.2.3 **Focus group discussions with pregnant women**

Focus group interviews were conducted with pregnant women receiving antenatal care at the clinics. The interview guide was grounded in the quantitative results from the self-administered questionnaire and the reviewed antenatal card. An "emergent-systematic focus group design" as described by Onwuegbuzie, Slate, Leech and Collins(2009) was used in one clinic where the emergent focus group was used to explore themes from the designed interview guide and the systematic focus groups were used to verify the findings.

Participants were informed about the interview to be conducted a month later to allow them time for thought about the process. The criteria for participation in focus group interviews was that the woman should be in her third trimester of pregnancy and should have had a minimum of four antenatal care visits, which would have offered her an opportunityto establish her psychosocial needs.

The pregnant women interviewed shared similar characteristics as they were within the childbearing age, of similar social class, and did not know one other, which would likely encourage a more honest and spontaneous expression of views.

The interview guide for pregnant women contained the following open-ended and closed-ended questions (See Appendix W):

An opening and introductory question:

"Please tell me about the care and support you received from midwives during your antenatal care visits"

Transition question:

"What type of care and support did you expect from the midwives?"

"Was the care and support that you received from the midwives what you expected?

Key questions:

"Did the care and support fulfill your needs?"

"*Is there anything that you do not like about your clinic visits / care?"*

Ending question:

"Is there anything that you wish should be done for you during your antenatal visits?"

The participants in each focus group were sampled from a pre-existing group from a population of women attending antenatal care at the time, and as such would be able to address this sensitive and personal topic as there might already be a sense of belonging between them. This would allow them ample opportunity to comment, explain and share experiences and attitudes. Self-disclosure among participants was promoted through homogeneity of participants, establishment of trust amongst participants and researcher, a comprehensive covering letter and the researcher's non-threatening probing.

Responses were recorded on an audiotape, transcribed verbatim and analyzed for themes. Data analysis commenced simultaneously with data gathering. The interviews lasted for ± one hour. Women were thanked for their participation and given smallgifts as a token of appreciation.

3.7.2.4 **In-depth interviews with midwifery experts**

In-depth interviews were conducted with midwifery experts. Experts within this study were individuals with advanced knowledge of the day-to-day management of pregnant women (Metzler and Davis,2002). The potential participants were Registered advanced clinical

midwives, midwifery lecturers from nursing colleges and universities' nursing departments and midwives in private practice.

3.7.2.5 The researcher as the interview moderator

The skills that were applied by the researcher as a moderator included possession of adequate knowledge regarding psychosocial risk factors and psychosocial support, mental preparedness, being alert, attentive, probing and exercising gentle and unobtrusive control of the discussion. Evidence from focus group interviews indicates that participants do influence one another with their comments, and in the course of a discussion the opinion of an individual might shift. The researcher was able to detect such shifts and its influencing factors (Krueger, 1994).

3.7.3 Phase 3: Report Writing

During phase 3 quantitative results and qualitative findings were reported separately following data analysis.

3.7.4 Phase 4: Guidelines and Recommendations

Guidelines and recommendations for psychosocial care were formulated, based on the findings from data analysis and other reviewed literature. Recommendations regarding psychosocial care were made for the midwifery curriculum, midwifery regulation, midwifery education and training, clinical midwifery and research.

3.7.5 Phase 5: Pilot Study

Clinical guidelines for psychosocial assessment and psychosocial support were designed and piloted in the clinics that participated in the study

3.7.6 Phase 6: Integration of Results and Findings and Writing of Final Report

Quantitative results and qualitative findings were integrated and the final report written in phase 6.

3.8 DATA ANALYSIS

Quantitative data analysis consisted of descriptive exploratory procedures followed by inferential procedures. Qualitative data analysis consisted of the identification of themes and relationships using the constant comparative method, which enabled the researcher to establish group and across-group saturation from focus group discussions.

The general approach to data analysis was based on Onwuegbuzie and Teddlie's seven stage conceptualization process (Johnson et al, 2004). The stages are: data reduction; data display; data transformation; data correlation; data consolidation; data comparison and data integration. These steps were applied to both quantitative results and qualitative findings.

Data transformation was achieved through the conversion of qualitative data into numerical codes that were analyzed by use of statistics, and the conversion of quantitative data into narrative data that were analyzed by use of themes. Quantitative data were correlated with qualitative data and consolidated to produce more data sets. Data integration was done after data from both quantitative and qualitative sources were compared for similarity and differences.

The dimension of data was reduced quantitatively through descriptive statistics, exploratory factor analysis and cluster analysis, and qualitatively through exploratory thematic analysis. Data were displayed quantitatively by the use of tables and graphs, and qualitatively through lists, charts, graphs and rubrics. The description of quantitative and qualitative data analyses follows:

3.8.1 Quantitative Data Analysis

Quantitative data were analyzed using Stata Release 10 statistical software. Data analysis generally included summary statistics (mean, standard deviation for continuous variables, frequencies and percentages for discrete variables) and Chronbach's alpha for internal consistency. Confidence intervals of 95% were used to report for discrete variable.

3.8.2 Qualitative Data Analysis

Qualitative data analysis occurred concurrently with data collection. To enhance the depth of qualitative analysis, multiple approaches to data analysis were used (e.g. constant comparison, thematic analysis, framework analysis) comparing themes and categories as a form of across-case analysis technique. The process of qualitative data analysis was rather aimed at bringing meaning to a situation than searching for the truth as with quantitative data analysis. A one- hour interview took approximately six hours to transcribe from audiotape and notes. The stages that were involved in reducing data were examining, categorizing and tabulating data (Rabiee, 2004). Data analysis was systematic, sequential, verifiable and continuous in order to minimize potential bias. A “Framework Analysis” was mostly used in qualitative data analysis.

3.8.3 The Framework Analysis

The framework analysis method of Krueger (1994) was adopted as it provides a clear series of steps which can easily manage large amounts of complex data. The approach is grounded on the original accounts and observation of the people studied, which is inductive. It also starts deductively, based on the aims and objectives of the study. Framework analysis involves a number of distinct and interconnected stages. This analytic process is systematic and designed in such a way that others can view the process and interpretations with ease (Pope, et al, 2000). The analysis continuum was based on raw data, descriptive statements then interpretation. The five key stages used for framework analysis were:

Familiarization: Familiarization with data was achieved through listening to the tape and reading transcripts several times, reading observational notes and the summary recoded after interviews. The aim was to immerse oneself in the data and get a sense of the whole interview.

Thematic framework: Memos were written in the margin of the text in the form of short phrases, ideas and concepts arising from the text, forming descriptive statements.

Indexing: Data were sifted and highlighted. Codes were sorted and compared. A theoretical framework was developed from the established themes.

Charting: Codes were rearrangedunder newly emerging thematic content. Data were compared and contrasted, cut and pasted under similar quotes.

Mapping and interpreting data: This was the final stage of qualitative data analysis. This was achieved through making sense of the individual quotes, establishing the relationship between quotes and creating links between the data as a whole.

The combination of data types occurred when analyzing qualitative and quantitative data that emerged from the self-administered questionnaires. Data were then organized in a spreadsheet according to major themes.The two sets of results, qualitative and quantitative, were presented separately and then compared, contrasted, corroborated, refuted, augmented, and integrated at the discussion level. The latter was achieved through transforming themes that emerged from qualitative data into ordinal data and analyzed statistically. Subsequently, some data from qualitative findings were transformed into themes and analyzed statistically.

3.9 VALIDITY VERSUS TRUSTWORTHINESS

3.9.1 Validity and Reliability

Validity for this study was based on the most cited definitions of validity by Winter (2000), which refer to an account being valid or true if it accurately represents those features of the phenomenon that it intends to describe or explain. With the quantitative approach the two main constructs characteristic of validity are accuracy and measuring what it intends to measure. Reliability is equally important for both qualitative and quantitative approaches as its concern is to establish whether the research is measuring what it is supposed to measure.

Reliability focuses on replicability and stability which represent the ability to consistently reproduce the same measurement using the same instrument (Winter,2000). Descriptive, interpretative, evaluative and generalizability or external validity were applied to this study. Descriptive validity was applied through the description of the methodology and procedures of data gathering and data analysis. Interpretative validity was maintained through a structured and clear presentation and the interpretation of the research findings.

The findings of this study relate to the phenomenon under investigation and no other intervening variables, justifying internal validity. An account is judged valid, replicable and stable based on generalizability. The ability to generalize findings to a wider population was mostly applicable to the quantitative part of the study. Sufficient data were included in reporting findings to allow the reader to judge whether the interpretation offered is adequately supported by the data available.

3.9.2 **Trustworthiness**

For the qualitative part of the study, trustworthiness was based on direct involvement of participants, midwives and women in negotiating the truth through subjective accounts of personal experiences, and meanings of reality from their perspective. What matters for validity in the qualitative approach is how representative the description is and how justifiable the findings are. The verification procedures included triangulation of methods and data sources, member checking, peer review, a thick description of the research process, respondent validation, reflexivity, inter- coder agreement, academic adviser's auditing, dealing fairly with obtained data and attention to negative cases (Popeet al, 2000)

Triangulation was applied through the use of mixed methods, obtaining data from multiple sources, using a variety of data collection methods, and implementing qualitative and quantitative data analysis. Triangulation allowed the limitations of one method to be compensated by the strength in another method. A clear exposition of methods, data collection and data analysis was presented. Another researcher was involved in coding data using previously agreed coding criteria in order to validate themes.

Respondent validation was addressed through probing during focus group interviews to validate the responses from participants and through the comparison of commonalities of responses from different data sources. A personal diary was kept by the researcher for reflection, recording events that occurred during the data collection process that were relevant to the phenomenon under investigation.

The distance between the researcher and participants was reduced through, for example wearing a uniform used by midwives while collecting data. This led midwives to identify with the researcher as a colleague, and to women as a familiar person similar to any midwife involved in their care. Deviant case analysis was included to establish elements in the data that contradicted any emerging themes related to psychosocial care.

The overall validity of both the qualitative and quantitative approaches was established through the presentation of the research proposal for peer review within the University's nursing department, submission of the research proposal to the University Human Research Ethics Committee for ethical clearance (Appendix A), presenting the proposal to the Faculty of Health Science postgraduate committee, supervision of the process by experts in research methods

who hold various constructivist and positivist philosophies, constant peer review, and the final examination of the research report by internal and external examiners.

Shadish, Cook and Campbell (2002) and Onwuegbuzie et al (2006), refer to internal validity, construct validity, external validity and statistical conclusion validity. Validity versus trustworthiness in qualitative research has been explained as credibility, dependability, transferability and confirmability by Lincoln and Guba (1985).

3.9.3 Legitimation Process

A legitimation process, as described by Onwuegbuzie et al (2006) addresses validity for mixed methods research. Both quantitative and qualitative legitimation models were applied. The following nine legitimation processes were applied in this study.

3.9.3.1 Sequential legitimation

Although the sequence was quantitative-qualitative, the results would still be the same even if the approach was qualitative-quantitative. This excluded any possible threat to legitimation

3.9.3.2 Sample integration legitimation

Quantitative and qualitative data were collected from the same population of pregnant women in the different antenatal clinics. The quantitative data were obtained through self-administered questionnaires and the review of the women's antenatal cards. The questionnaires contained both closed-ended and open-ended questions. Qualitative data were collected through focus group interviews from the very population that completed the questionnaires and whose antenatal cards were reviewed. This sample integration allowed inferring from both quantitative and qualitative findings derived from the same population.

3.9.3.3 Paradigmatic mixing legitimation

Both quantitative and qualitative paradigmatic assumptions were taken into consideration as unique entities and later integrated. The researcher's epistemological, methodological, ontological, axiological and rhetorical beliefs that underlie the quantitative and qualitative approaches were treated as separate, but used complementarily and as compatible. This was managed through recognizing subjective, inter-subjective and objective realities, recognizing the interaction between the internal and external realities described by participants, describing the "value-ladeness" of the study, the use of both formal and informal writing styles, and not being biased by one method over the other.

3.9.3.4 **Multiple validities legitimation**

Both validity and trustworthiness were taken into consideration in this study to assist in producing high quality inference of findings.

3.9.3.5 **Inside-outside legitimation**

Inside-outside legitimation refers to the “etic” and “emic” viewpoints regarding the research. These viewpoints, the latter refers to the interpretations of data by those studied whereas the former refers to the researcher’s interpration of data. Inside-outside legitimation in this study was achieved through the use of a mixed-method approach, as such, the quantitative part sought an objective view of the phenomenon under study and the qualitative part addressed the subjective viewpoint; obtaining justification of the interpretation of responses throughout focus group discussions, i.e member checking and the findings of the study being peer reviewed.

3.9.3.6 **Weakness minimization legitimation**

The weaknesses of both quantitative and qualitative approaches were compensated by the strengths of both approaches. Combining a weak inference from one approach with a strong inference from another approach during data analysis and interpretation led to a high quality meta-inference.

3.9.3.7 **Conversion legitimation**

Conversion legitimation, as stated by Onwuegbuzie et al (2006), refers to the extent to which data conversion techniques lead to interpretable data and inference quality. Data conversion in this study was achieved through obtaining counts of qualitative data or observations in addition to the narrative description, to provide interpretable data with a high quality inference. Counting of qualitative themes was obtained, where appropriate, from self-administered questionnaires for both midwives and pregnant women and from reviewed antenatal cards. Counting of themes provided additional information of how often or how many. Narrative descriptions from quantitative data were constructed to qualitize data through average and comparative profiles. Conversion legitimation provided a fully mixed world view of the research process and meta-inferences.

3.9.3.8 **Commensurability legitimation**

The Gestalt switch approach was used as the researcher switched from the quantitative lens to a qualitative lens, by going back and forth throughout the research process.

3.9.3.9 **Political legitimation**

Political legitimation,is a challenge of politics that researchers face as a result of combining both quantitative and qualitative approaches, which refers to power and value tensions. The tension includes ideologies based conflicts amongst quantitative and qualitative researchers used in the same study. Contradictions and paradoxes might also arise during the analysis and contrasting of qualitative and quantitative data.

Political legitimation in this study was overruled through the following:

- The use of one researcher for collecting both quantitative and qualitative data.
- The researcher having access to all stake-holders to address psychosocial risk assessment and psychosocial support during antenatal care.
- More power placed in the hands of the participants for qualitative subjective data and the researcher acted as a collaborator and facilitator.
- The study being mentored by a qualitative and a quantitative researcher who advocated pluralism in research.
- The researcher ensuring that the findings and results answered the research questions and the conclusion provided workable solutions.

3.10 ETHICAL CONSIDERATIONS

The appropriate steps to ensure approval of the study and the protection of the rights of the research informants included:

- Permission to conduct the study, obtained from the University of the Witwatersrand's Health Science Ethics Clearance Committee(Appendix A).
- Permission from the Department of Health, The South African Nursing Council, the three Nursing Colleges and the Health Care Centres (Appendix B, C and D).
- Permission obtained from the Provincial Research Committees (Appendix E).
- Voluntary participation of subjects and guaranteed freedom to withdraw at any point of the study.
- Anonymity of the participants by use of pseudo names and codes.
- Protection of basic human rights i.e protection from discomfort and harm, fair treatment, self-determination, anonymity and confidentiality, privacy and dignity.

3.11 **CONCLUSION**

Chapter 3 described the exploratory and explanatory methodological approaches used in the study. A thick description of data sources and the process of data collection were outlined. Various approaches to qualitative and quantitative data analysis were described. Chapter 4 describes quantitative results.

CHAPTER 4

4. THE PRESENTATION AND DISCUSSION OF QUANTITATIVE PHASE RESULTS

4.1 INTRODUCTION

Chapter four presents the results of the quantitative phase. Data were obtained through the review of the South African Nursing Council curriculum and the Midwifery Regulations (R425, R254, R2488 and R2598). Included were the midwifery education and training curriculum, the learning guides, formative and summative clinical tools, tests and examination papers for midwifery for the Government Nursing Education Colleges in Gauteng Province, and the Gauteng Department of Health Antenatal Care Policy Document (1997). The documents and records were specifically reviewed to assess the extent to which psychosocial care in midwifery was included.

Another set of data were obtained through a self-administered questionnaire from pregnant women attending antenatal care in three Gauteng clinics(Appendix S). Women'santenatal cards were simultaneously reviewed with the administration of the questionnaires. Data were also obtained from midwives through self-administered questionnaires at the 8th Annual Congress of Midwives that was held during December 2009 (Appendix L).

The data sets provided multiple data sources, a characteristic of themixed methods approach. Data were analyzed using the Stata Release 10 statistical software package. Data analysis included summary statistics i.e. mean and standard deviation for continuous variables, frequencies and percentages for discrete variables, and Chronbach's alpha for internal consistency. Confidence intervals of 95% were used to report on discrete variables. Most of the results are presented as percentages.

4.2 RECORDS AND DOCUMENT REVIEW

4.2.1 Midwifery Education Documents Review

The three Gauteng Nursing Colleges' Midwifery education and training documents that were in use from 2004 to 2008 were reviewed. The five year period was selected to accommodate any changes or updates that could have been done on the documents earmarked for review.

4.2.2 The South African Nursing Council (SANC) Midwifery Regulatory and Midwifery Education documents

4.2.2.1 The macro curriculum

The curriculum specifies the course objectives regarding the student midwife's personal and professional development under section 2, subsections a, b and e as follows:

- The student should show respect for the dignity and the uniqueness of man in his socio-cultural and religious context and approaches, and understand him as a psychological, physical and social being within the context.
- The student should be skilled in diagnosing individual, family, group and community health problems, and in the planning and implementation of therapeutic actions and nursing care for the health service of consumers at any point along the health/illness continuum at all stages of the life cycle.
- The curriculum endorses the principle that a comprehensive health service is essential to raise the standard of health of the total population, and in practice contributes to the promotion of such services.

4.2.2.2 The SANC midwifery regulations

The four variables used for psychosocial assessment and psychosocial care for the review of midwifery regulations were physical, social, psychological health factors and collaboration. These are the concepts used in describing the outcomes prescribed for each regulation. The concept collaboration has been adopted from a literature review on integrated perinatal care byRodríguez and des Riviėres-Pigeon (2007),which defines the conceptas a cooperative inter-organizational relation that lead to the consideration of the integration of health services as a process of institutionalizing collaboration across the health care systems, through a process of sustained communication.

Collaboration within the context of this study was addressed through comprehensive management of women by referring them to allied health care services when a need arose. The analysis of each Regulation was achieved through counting all the objectives and classifying them under each of the four variables and establishing a percentage based on the number of objectives versus the total in the Regulation. See Table4.1.

Table 4.1: SANC Midwifery Regulations: physical, social, psychological and collaboration content

SANC Regulations	Physical care	Social care	Psycho -logical care	Colla-boration	Total	Physical care %	Social care %	Psychological care %	Collaboration %	Frequency of psychosocial care %
R2598	23	3	5	3	34	67.6	8.8	14.7	8.8	32.4
R2488	6	0	0	0	6	100.0	0.0	0.0	0.0	0
R387	7	2	1	3	13	53.8	15.3	7.6	23.0	46.2
R425	10	1	1	2	14	71.4	7.1	7.1	14.3	28.6
R254	0	8	8	0	16	0.0	50.0	50.0	0.0	100%

4.2.2.2.1 **Regulation 2598 of 30 November 1984 as amended**

This Regulation explicates the guidelines pertaining to the Scope of Practice for midwives. Chapter 3 of the Regulation stipulates the following scientific procedures which apply to the practice of midwifery:

- 3(a) the diagnosing of a health need and the facilitation of the attainment of optimum physical and mental health for the mother and child by the prescribing, provision and the execution of a midwifery regimen or referral to a registered person.
- 3(c) the prevention of disease relating to pregnancy, labour, puerperium and the promotion of health and family planning by teaching and counseling individuals, families, groups by the implementation of family planning skills and monitoring the health status of the mother and child.
- 3(d)iii the monitoring of the reaction of the mother and child to disease conditions, trauma, stress, anxiety, medication and treatment.
- 3(g) the prescribing, promotion or maintenance of hygiene, physical comfort and reassurance of the mother and child.
- 3(q) the facilitation of communication with the family in the execution of the midwifery regimen.
- 3(r) the establishment and maintenance of an environment in which the physical and mental health of the mother and child is promoted.
- 3(t) the coordination of the health care regimen provided for the mother and child by other health care categories.
- 3(u) the provision of effective advocacy to enable the mother and child to obtain the health care they need.

There is an inclusion of the psychosocial aspect within Regulation 2598. This is evidenced by the inclusion of concepts like optimum mental health, counseling of individuals, monitoring trauma, stress and anxiety, an environment that promotes the mental health of the mother, advocacy, coordination of care and referral of the woman. The psychosocial component of Regulation 2598 accounts for 32% as reflected in Table 4.1, which is a reasonable representation.

4.2.2.2.2 Regulation 2488 of 1990 as amended

The focus of this Regulation is on advocacy and communication. This is reflected under chapter 2, subsection 6(b) which states that the midwife should "ascertain whether any abnormality which could have an adverse effect on the present confinement has occurred during a previous pregnancy, labour or pueperium, and if so, advise the patient to seek medical advice". The focus of Regulation 2488 emphasizes only physical care.

4.2.2.2.3 Regulation 387 of 1985 as amended

R387 stipulates the guidelines pertaining to the conditions under which the South African Nursing Council may take disciplinary action. This is reflected in chapter 2 subsection (3) and chapter 3 sub section 30(d) as follows:

- Willful or negligent omission to carry out such acts in respect of diagnosing, treatment, care, prescribing, collaborating, referral, coordinating and patient advocacy as the scope of the profession permits.
- Willful or negligent omission to maintain the health status of the patient through the correct identification of the patient, determining the health status of the patient and the physiological responses of the body to disease conditions, trauma and stress,
- Willful or negligent omission to offer specific care and treatment of the vulnerable, high risk mother and child, the seriously ill, the disturbed, the confused, the unconscious patient and the mother with communication problems, which include psychosocial aspects.

The psychological component included within regulation 387 accounts for 46% as reflected in Table 4.1.

4.2.2.2.4 Regulation 425 of 1985 as amended

The Regulation outlines the duration of the program of instruction leading to a Diploma in (General Nursing, Community, Psychiatry) and Midwifery as four years. It stipulates the admission requirements for the four year program and it describes the content that should be covered as part of the curriculum. It specifies the duration of midwifery training within the four year program, which is two academic years. The subject content that the student should learn includes midwifery, psychiatric nursing science, social science, community health nursing and general nursing science. The combination of these subjects provides a comprehensive approach to learning.

Within the Regulation's program objectives there is the requirement for psychosocial care i.e., comprehensive and multidisciplinary care as stipulated under subsections 2(a), 2(c), 2(f) and 2(l) as follows:

2(a) the student shows respect for the dignity and uniqueness of man in his social-cultural and religious context and approaches and understands him as a psychological, physical and social being within this context
2(c) is able to direct and control the interaction with health service consumers in such a way that sympathetic and empathic interaction takes place
2(f) is able to collaborate harmoniously within the nursing and multidisciplinary team in terms of the principle of interdependence and cooperation in attaining a common goal
2(l) is acquainted with the extent and importance of the environmental health services and knows the professional role and responsibilities in respect of the services and in respect of personal professional actions where the services are not available

A holistic approach is reflected within Regulation 425 and it accounts for 28.6% of psychosocial care as per Table 4.1.

4.2.2.2.5 Regulation 254 of 1975 as amended

Regulation 254 addresses the basic sciences that should be taught to students studying for the four year diploma course, viz. Social sciences, Social care, and Mental Health. The Regulation also lists the criteria to be met by a tutor who should teach Social science.

Regulation 254 further highlights the Social science content that should be taught from the first year of training. The patient should be viewed as part of a family rather than as an individual. The sociological concepts that should be covered are:

- biological, physiological and ecological influences on society
- demographic aspects of health care
- the socialization process
- culture
- social stratification
- interviewing and counseling
- Social Science should include social pathology that is significant to health and the social assistance that is available to address the pathology
- social care, social assistance and welfare services

Regulation 254 further states that psychology and mental health should include: the human personality, emotions, attitudes, motivation of conduct, frustration and conflict, group morale and communication. Specific attention should be given to psychosomatic and psychopathological conditions as they relate to midwifery and to the child. Mental health care should also be provided. Regulation 254 focuses exclusively on the social and psychological content that should be covered during the teaching of students for the four year program. It does not reflect anything pertaining to physical care.

4.3 THE GAUTENG DEPARTMENT OF HEALTH ANTENATAL CARE POLICY GUIDELINES (1997)

This is a policy document mandating the minimum standards package of antenatal care for the Gauteng Province. The policy serves to define standards of antenatal care within the Province. It serves as a form of communication to pregnant women and their families and guides midwives and other health care providers in respect of the minimum standards of antenatal care. Table 4.2 highlights the policy's perspective on the antenatal care first visit, what constitutes risk during pregnancy, and problems arising during pregnancy with reference to psychosocial care. Within this list, psychosocial care is not classified except that it forms part of the objectives of antenatal care in a broader view.

Table 4.2: The Gauteng Antenatal Care Policy Document: Physical; Social; Psychological and Collaboration Content

Gauteng Antenatal Care Policy Document	Physical care	Social care	Psychological care	Total	Psychosocial care %
Antenatal first visit	5	1	0	6	16,6%
High risk conditions	21	2	0	23	8,6%
Intermediaterisks	5	0	0	5	0%
Problems arising in pregnancy	10	0	0	10	0%

4.3.1 The Objectivesof Antenatal Care

The general objective of antenatal care, as stated on page 4 of the policy guideline, is to "ensure the best possible pregnancy outcomes for pregnant women and their unborn babies through optimal physical and psychological preparation before delivery" The two specific objectives of the province are stated as "the eradication of congenital syphilis and the rate of unbooked emergencies", which focuses on biophysical care and management. For the objective to be realistic it should rather be stated as "the prevention of syphilis and the avoidance of unbooked emergencies", although the concept of a "booked emergency" is very odd.

4.3.2 The Levels of Antenatal Care

The levels of care under "risk category" are referred to as low risk, intermediate risk (e.g. previous caesarean section), high risk (e.g. hypertension), and special risk (e.g. diabetes). The focus for risk is on physiological risks as per examples listed.

This policy further stipulates that disciplines allied to midwifery care, such as social workers and physiotherapists, should be available to provide support to the antenatal clinic. A full range of referral facilities should be on offer at central hospitals. This aspect promotes a multidisciplinary approach which is important for psychosocial care.

4.3.3 The Antenatal First Visit

The policy states that the history that is obtained should include the following data:

- Personal details, age, address and contact number.
- Past obstetric history including the complications and outcomes of previous pregnancies.
- Medical and family history, psychological health, and conditions affecting or that may be affected by pregnancy.
- A problem list of anticipated or observed risk factors.

4.3.4 Information for Pregnant Women

It is stated in the policy that there is a need to maintain friendly and open communication between the antenatal staff and the pregnant women attending antenatal care. The information that should be shared with the women includes a delivery plan, danger signs and symptoms, preparation for childbirth and motherhood. Verbal communication should be augmented by information leaflets. Although information focuses on physiological risks, communication is very important in facilitating psychosocial care.

4.3.5 Appendix 1: A List of High Risk or Intermediate Risk Problems

The list provided in the policy includes medical conditions related to pregnancy, the risks in relation to previous obstetrical history, infertility, history of congenital defects, surgical interventions, maternal age of 15 years or less, parity of 5 or more, problems arising during the current pregnancy, and psychiatric illness, (including previous puerperal psychosis). See Table 4.2 for the frequency of physiological factors versus psychosocial factors.

In conclusion, the focus of the policy is on physical and psychological care as reflected under the objectives. Although acknowledging disciplines allied to midwifery care, the social health of the woman is not taken into consideration regarding both the objectives and the listed risk factors.

4.4 THE GAUTENG ANTENATAL CARE CARD

The document is referred to as TPH 261 (81/530383).The first page reflects a framework in the form of a guideline for the recording of maternal history during the first booking at the antenatal clinic. The information to be collected is the mother's personal history which includes the address and contact number, the obstetric history, family planning used and future family planning,and the person's social, medical, general and family history. There is a column to record all the assessment details.

The second page of the antenatal card provides an example of the graph used to monitor foetal growth by means of estimating the gestational period and measuring the height of the uterine fundus. Maternal observations that should be monitored are the weight, blood pressure, odema and urinalysis. A problem column allowing forfive problems is provided. Notes for the recording of essential facts also form part of page 2 of the antenatal card. However, there is nothing specific regarding psychosocial assessment and psychosocial care within the antenatal card.

4.5 GUIDELINES FOR MATERNITY CARE IN SOUTH AFRICA

The guidelines for maternity care are stipulated in a manual for clinics, community health centres and district hospitals by the Department of Health of South Africa (2007). The first two objectives of antenatal care are to screen the woman for pregnancy problems and to assess the woman for pregnancy risks; however, the guidelines do not specify whether there are physical or psychosocial risks. Other objectives stated are the provision of information to pregnant women, and physical and psychological preparation for childbirth and parenthood.

The guidelines also state that in preparing the woman for pregnancy, consideration should be given to mental health, social, economic and family issues, which basically represent a focus on psychosocial problems or risks. History taking should include history of psychiatric problems, the use of alcohol, tobacco and other substances, family and social circumstances. Although psychosocial concepts are broadly presented, the guideline highlights a holistic approach in managing pregnancy, which includespsychosocial care.

4.6 THE GAUTENG NURSING COLLEGES' MIDWIFERY EDUCATION RECORDS

The records that were reviewed within the Nursing Colleges were for the courses offered within the Midwifery and general Diplomas, the latter covering General, Community and Psychiatric Nursing. The records perused included the midwifery curriculum, the learning and teaching guides, clinical formative and summative tools and tests and examination papers for both first year midwifery (Midwifery 100) and second year midwifery(Midwifery 200). The purpose of the review was to establish the extent of the inclusion of psychosocial aspects of midwifery care.

4.6.1 The Midwifery Curriculum for Gauteng Nursing Colleges

The midwifery curriculum is designed for all three colleges in Gauteng province that offer basic midwifery education. The curriculum was revised by the Gauteng Curriculum Committeeduring May 2007.

Preamble

The preamble with the overall aim of the provision of diversified comprehensive health care includes reference to violence and trauma and mental health. It further aims at educating nurses to assess and meet the health care needs of individuals, families, groups and communities.

The midwifeis described by the South African Nursing Council as a provider, a collaborator and a facilitator of health care. The advocacy role highlights that a midwife should be able to adapt to change, analyze and solve problems, communicate effectively and adopt an ethos of caring. She also has an important task of health counseling and education (as part of the definition of a midwife). These principles are important in offering psychosocial care.The colleges hold a philosophical view that says “every human being has unique physical, psychological, social and spiritual needs with a complex set of values and beliefs”. This philosophy offers a holistic approach to caring for women during childbirth (GPG, 2007).

The associated assessment criteria include communication, empathy, cultural sensitivity, a caring attitude and a consideration of the rights of clients by the midwife. The curriculum, under the program objectives, presents criteria for professional growth and development of a student on completion of the course as follows:

- To show respect for the dignity and uniqueness of each woman in her socio-cultural and religious context.
- To approach and understand her as a psychological, physical and social being within this context.
- To be able to collaborate harmoniously within the nursing and the multidisciplinary team in attaining a common goal.
- To be acquainted with the extent and importance of the environmental health services.
- To be able to promote community involvement at any point along the health/illness continuum and in all stages of the life cycle.
- To be part of the critical cross-field outcomes the student should also demonstrate an awareness of the importance of being culturally and aesthetically sensitive across a range of social contexts.

Midwifery Nursing Science 100 (MNS 100)

The exit outcome for midwifery first year course (MNS 100) states that the student midwife will render effective holistic midwifery care to a low risk woman and child during antenatal care, labour and the postnatal period. One of the specific outcomes states that “the learner should demonstrate knowledge and sensitivity to psychosocial, cultural and spiritual diversities during rendering midwifery and neonatal care”.

Midwifery Nursing Science 200 (MNS 200)

The exit outcome for midwifery second year course (MNS 200) states that the student midwife will render effective holistic midwifery care to a high risk woman and child during the antenatal period, labour process and the postnatal period. The student has to display socio-cultural sensitivity when interacting with mother and family, accurately assess a high risk woman and identify health needs, refer when necessary and successfully implement health education sessions.The curriculum generally justifies the need for holistic care and comprehensive management of a woman during childbirth.

4.6.2 **The Midwifery Learning Guides**

The information regarding psychosocial care that is included in each of the three colleges' learning guides is discussed below.

4.6.2.1 **Midwifery nursing science 100 (MNS 100)**

The Midwifery 100 course aims to equip the student midwife to render care to women with low risk or normal pregnancy, labour and pueperium. The definition of pregnancy is reflected as a rationale for antenatal care and it is viewed as a stage not only of physiological change but of psychological adjustment. Antenatal care is aimed at ensuring the best possible pregnancy outcomes for pregnant women and their unborn babies through optimal physical and psychological preparation before delivery. Pregnancy is furthermore viewed as a long term process affecting not only the woman, but her family. A midwife should therefore be able to give necessary supervision, care and advice to women and their families during pregnancy, considering the psychosocial and spiritual needs of the woman.

One of the three colleges' learning guide expanded upon the rationale and stated that the aim of the MNS 100 course is to enable the learner to render holistic care in preconception and reproductive health, to understand the psychological and physiological changes during pregnancy and their effect on the pregnant woman, and to holistically promote maternal and foetal wellbeing. The specific outcomes are stated as: the application of good communication; to explore the socio-economic implications of pregnancy and parenthood; to explain the woman and the family's reaction to conception, and to explain midwifery interventions to overcome the reaction. (An example could be, as revealed in subsequent midwives' focus group interviews, that showing the woman her baby through sonar normally changes her reaction to conception in a positive way).

According to the learning guide of this particular college, a social and personal history should be collected as part of the woman's assessment. The psychological reaction of a woman to labour, and the psychology of the pueperium and the specific outcomes to be achieved for midwifery care are included within the guide. The exit outcome states that "the learner will render effective holistic midwifery care to a low risk pregnant woman and the newborn during the antenatal, normal labour and postnatal period, including neonatal care using the scientific nursing approach within the legal ethical framework in a comprehensive health care system".

As part of the specific focus, psychosocial, spiritual learning needs, and health education are included. "The learner has to demonstrate knowledge and sensitivity to psychosocial, cultural and spiritual diversities while rendering obstetric care". A learning unit on socio-cultural and religious aspects is also included within the learning guide.

The specific outcomes are stated in the MNS 100 course learning guide as follows:

- Demonstrate knowledge and sensitivity to psychosocial, cultural and spiritual diversities while rendering obstetric/midwifery care
- Advocate for the rights of the mother and child
- Render care to the pregnant woman and her family during low risk pregnancy in accordance with the Scope of Practice for Midwives (R.2598), the Patient's Rights Charter, Batho-Pele principles, and relevant policies,Acts and Guidelines published by the Department of Health.

The MNS 100 learning guide also reflects the following activities:

History taking including social history, student midwives viewing a45-minute video on psycho-physiological changes during pregnancy, and a demonstration ofcomprehensive assessment of a pregnant woman by the clinical facilitator.

4.6.2.2 **Midwifery nursing science 200 (MNS 200)**

The outcome of MNS 200 course according to SANC Regulation 2488 addresses high risk antenatal care, labour, postnatal care and the high risk neonate. The MNS 200 course learning guides for the threecolleges defines a high risk pregnancy as a pregnancy that introduces probable and or definitive health problems leading to an increased threat or danger to the life and or health of the mother and her unborn baby. These health problems include medical conditions, pregnancy-related complications, and age and parity-related problems. If these

health problems are not well managed, they may lead to increased maternal and perinatal morbidity and mortality. In order to eliminate or reduce the threat and or dangers associated with these health problems, all pregnancies must be thoroughly and regularly assessed in order to determine any prevailing and or anticipated risk factors, and be referred appropriately. The student midwife is further urged to be able to apply the scientific processes in order to render holistic antenatal care to ensure the best possible pregnancy outcomes.

A learning outcome states that the learner should be able to render care to the pregnant woman and her family during high risk pregnancy in accordance with the Scope of Practice Regulation 2598(SANC), the Patient's Rights Charter and Batho-Pele Principles (Batho Pele White Paper No. 1459,1997) and relevant policies, Acts and Guidelines published by the Department of Health. Learning objectives list medical conditions.

Although thecontextual definition of antenatal care in the learning guides of the colleges is confined to medical problems, the student is further directed to apply the knowledge and assessment of psychosocial spiritual needs as learned during the first year of study. In the learning guide of one of the colleges that participated in the study, the purpose of learning for the MNS 200 student midwife was to be able to render effective holistic midwifery care to a high risk woman during the prenatal, intra-partum and postnatal periods including high risk neonatal care, using the scientific nursing process within the legal-ethical framework in a comprehensive health care system, which implies a focus on the physical, social, psychological and cultural aspects of the woman's wellbeing.

The aim of midwifery care as stated in all three learning guides, is to develop the learner in applicable ethics, professional practice, national guidelines and policies, psychosocial and cultural aspects during complicated or high risk maternal and neonatal care. The anticipated benefits to the student include competency and the development of skills to provide comprehensive and total patient care during the prenatal, intrapartum, postnatal and neonatal periods. The benefits to the community, on the other hand, are stated as quality health care within the ethical-legal and psychosocial framework, comprehensive midwifery care and the acknowledgement by midwives of cultural values and beliefs or management by midwives according to cultural values and beliefs.

Two of the twelve exit outcomes assessment criteria focused on psychosocial care. The student has to be able to communicate effectively using a range of communication skills,

demonstrating knowledge and sensitivity to psychosocial cultural and spiritual diversities, while rendering obstetric midwifery and neonatal care. The following five of the twelve exit outcomes address the psychosocial aspect: the student must demonstrate knowledge and manage clients with specific problems, consult and refer appropriately, function within a multidisciplinary team, manage holistic basic prenatal, intrapartum, postnatal and neonatal care with emphasis on the promotion of health, advocate for the rights of individuals, family and groups, and communicate effectively with individuals, family, groups and community members within a multi-professional team.

A pre-knowledge for entry into MNS 200, derived from MNS 100 course, is stated as knowledge of the socio-cultural and religious beliefs related to midwifery practice. Psychosocial skills that should have been learned are: counseling; communication; problemsolving; planning a health care session and the mechanisms or the indications for a process required to refer the woman to the other health care team members when indicated. The stated pre-knowledge is crucial to psychosocial assessment and psychosocial support.

Critical cross-field outcomes demonstrate the awareness of being culturally and aesthetically sensitive across a range of social contexts, and further demonstrate the importance of an understanding of the world as a set of related systems by recognizing that problemsolving contexts do not exist in isolation.

The learning guide of one of the colleges highlights the comprehensive and holistic management of a pregnant woman. The guides of all three colleges contain outcomes relating to the problems of teenage pregnancy, puerperal depression and psychosis, all of which relate to psychosocial care.

4.6.3 **Formative and Summative Clinical Assessments**

The clinical tools or checklists for formative and summative assessment at the three colleges were reviewed as the clinical area constitutes an important context for the application of psychosocial care during pregnancy. Each tool used for assessment included at least an element of psychosocial care. The componentsof psychosocial care factors contained in the clinical tools were calculated against the physical care factors. Eight clinical evaluation tools for MNS 100 and five tools for MNS 200 were presented for review by the three nursing colleges. The psychosocial content range was 5.5% to 33,3% (Table 4.3) for the MNS 100 course and 5.7% to 35.7% for the MNS 200 course (Table 4.4).

Table4.3: MNS 100 Clinical Tools Component for the Three Colleges

Focus of Assessment	Physical care	Social care	Psychological care	Ethics	Health Info	Referral	Total / Psychosocial care %
Antenatal care	48	7	0	1	1	0	9/57 (*15.7%*)
Physical exam	25	1	1	1	1	0	4/29 (*16%*)
Low risk antenatal care	12	2	0	0	1	0	3/15 (*25%*)
Antenatal care summative	10	0	0	0	3	0	3/13 (*23%*)
Abdominal palpation	16	2	2	0	4	0	8/24 (*33,3%*)
Second stage of labour	34	2	0	0	0	0	2/36 (*5.5)*
Post natal care	18	2	2	0	0	0	4/22 (*18.1%)*
Neonatal care	34	3	1	0	0	1	5/39 (*12.8%)*

Table4.4: MNS 200 Clinical Tools Component for the Three Colleges

Type	Physical care	Social care	Psychological care	Ethics	Health Info	Referral	Total / Psychosocial care %
Formative case presentation	9	3	0	1	1	0	5/14 (35.7%)
Case presentation (competency)	90	5	0	5	5	0	15/105 (14.2%)
Summative antenatal care	16	5	2	0	1	0	8/24 (33.3%)
Summative postnatal care	33	0	1	0	1	0	2/35 (5.7%)
Case study summative	85	0	0	5	5	5	15/100 (15%)

Table 4.5: Clinical Psychosocial Content for MNS 100 and MNS 200

Component	MNS 100	MNS 200
Psychosocial care	38	45
Physical care	197	233
Total	235	278
Frequency	16.17%	16.19%

Table 4.5 provides a summary of psychosocial and physical care content in the clinical tools for the three Nursing Colleges in Gauteng Province for MNS 100 and MNS 200 courses. The proportion of psychosocial clinical facilitation does not differ significantly within MNS 100 and MNS 200 (p=0.996; 16.7% and 16.19%) but it is lower than the recommendation ofR.2598 which is 32.4%(Refer Table 4.1),which directs clinical practice for psychosocial care in midwifery.

4.6.4 Midwifery Clinical Practice Workbook for MNS 100

The workbook formed part of the formative clinical assessment component and is a standard for MNS 100 course formulated by the colleges. Amongst the outcomes stated in the workbook activities, students have to develop socio-cultural sensitivity. Antenatal care objectives include comprehensive assessment and care of ten low risk pregnant women in the antenatal clinic. Assessment should be carried out continuously to monitor the welfare of the woman and the foetus. Health needs are identified and provision is made for addressing them. To a certain extent, the assessment puts emphasis on the physical aspect of pregnancy, for example parity, expected date of delivery and abdominal assessment.

One college included an expanded psychosocial component to the workbook, a patient interview format was required to be completed by the student for women with first pregnancies. It addresses psychosocial factors by requiring students to ask the mother questions; for example:about preparations in place for the baby, feelings about and acceptance of the baby, how the baby is likely to affect the parent's lifestyle, factors which influence the acceptance of the baby, the available support systems, fears that the couple might have about the pregnancy, labour or baby, and lastly, the midwives intervention regarding identified problems. This is an ideal approach to psychosocial assessment and psychosocial care.

Cioffi (1998) and Pincombe (2003), highlight teaching strategies that develop clinical decision making skills like use of simulations, thinking aloud techniques, case study, reflection and experiential learning. The Wenger's Communities of Practice Model (1999), is also of the view that reflective practice is important for knowledge-based care, and that it is through communal reflection and communication that tacit knowledge is made explicit. Simulation provides a student with a safe environment that is conducive to learning without fear of putting the woman's life in danger. Simulation regarding psychosocial assessment can be undertaken by a pair of students with one being the simulator of the clinical experience and the other being the decision maker. For example one studentplaying the role of a pregnant woman during the initial history taking and the other student role-playing the assessing midwife, with direct observation by peer students and the facilitator. The student can also incorporate a "thinking aloud" technique simultaneously with simulation.

A case study can be undertaken in the form of a journey taken by a midwifery student and a pregnant woman's family. The student becomes part of every step of the process, for example accompanying the woman during antenatal visits and antenatal classes, clarifying issues to the

woman that relate to childbirth. Home visits also form part of the case study. The journey ends six weeks post delivery with the student documenting and reporting on the process. The case study approach gives the student an opportunity to manage the woman holistically. Reflection provides a potential for student's self reflection and correction, repeating the skill until it is mastered. Women's birth stories and research dissemination on psychosocial care can also assist with reflection in midwifery care.

Cioffi (1998) further states that, a student midwife comes to clinical practice with theoretical knowledge acquired through systematic study. This is referred to as declarative knowledge which consists of midwifery domain concepts and facts. The practical setting should further equip the student midwives with practical expertise and skills that will provide the student with decision making skills.

Midwifery 200 (MNS 200) assessment guidelines:

The guideline formed part of the clinical workbook.Psychosocial history, as reflected within the guideline, must include the name, age, marital status, occupation, education, income, support system, emotional status, high risk habits, planned or unplanned pregnancy, environment, keeping of baby or offering baby for adoption. The criteria for psychosocial care are described as: maintain privacy and sensitivity, continued emotional support of the client and the support system, respect for the client's personal space and decisions, appropriate referral, respond appropriately and correctly to identified problems or concerns raised by the client.

4.6.5 Written Assessment: Tests and Examinations for MNS (100) and MNS(200)

Tables 4.6, 4.7 and 4.8 illustrate the psychosocial versus the physiological components of theoretical formative and summative assessment of students from the three nursing colleges.Some colleges could not submit the required documents as reflected by N/S (not submitted). Regardless of the amount of data missing from the review, an overview for all the colleges indicates that over the selected years, psychosocial care is addressed to a very limited extent, during both formative and summative assessment of MNS 100 and MNS 200.

College 1 submitted 5-year period tests and examinations for review (2004-2008). An avarage of three tests was written for MNS 100 and two for MNS 200 during each year. For college 1, psychosocial care was reflected more in tests written for MNS 100 than MNS 200. Inboth year groups, the psychosocial evaluation in examination papers was less than what was evaluated in supplementary papers. This signifies a negative index, as supplementary examinations are

only written by few students that could not pass the main examination. Supplementary scores were as such, excluded from the final results presented in Table 4.6 b and Table 4.6 c and in the other two colleges.

Table 4.6(a): College 1 - Formative and Summative Written Assessment(NS=not submitted)

MNS 100

Year reviewed (t=test)	Formative Assessment		Total mark	Final %	Exam/Deferred		Total mark	Final %
	Psychosocial care content	Physical care content			Psychosocial care	Physical care		
2004 (3t)	5	145	150	3,3%	0	100	100	0%
					14	86	100	14%
2005 (3t)	0	150	150	0%	10	90	100	10%
					10	90	100	10%
2006(1t)	6	44	50	12%	0	100	100	0%
					10	90	100	10%
2007(3t)	18	132	150	12%	0	100	100	0%
					0	100	100	0%
2008 (2t)	0	100	100	0%	7	93	100	7%
					N/S	-	-	-

MNS 200

Year reviewed (t=test)	Formative assessment		Total mark	Final%	Exam/Deferred		Total mark	Final %
	Psychosocial care content	Physical care content			Psychosocial care	Physical care		
2004 (1t)	0	50	50	0%	0	100	100	0%
					0	100	100	0%
2005(1t)	0	50	50	0%	N/S	-	-	-
					20	80	100	20%
2006(2t)	0	100	100	0%	5	95	100	5%
					4	96	100	4%
2007 (1t)	0	50	50	0%	0	100	100	0%
					0	100	100	0%
2008 (3t)	0	150	150	0%	N/S	-	-	-
					N/S	-	-	-

Table 4.6(b): College 1

MNS 100 summary

Year of review	Tests	Exams
2004 (3t)	3.3% (5/150)	0% (0/100)
2005 (3t)	0% (0/150)	10% (10/100)
2006(1t)	12% (6/50)	0% (0/100)
2007(3t)	12% (18/150)	0% (0/100)
2008 (2t)	0% (0/100)	7% (7/100)

Table 4.6(c): College 1

MNS 200 summary

Year of review	Tests	Exams
2004 (1t)	0% (0/50)	0% (0/100)
2005 (1t)	0% (0/50)	N/S
2006(2t)	0% (0/100)	5% (5/100)
2007(1t)	0% (0/50)	0% (0/100)
2008 (3t)	0% (0/150)	N/S

No tests papers were submitted by College 2 for review for two academic years in either MNS 100 or MNS 200. A summary of the percentages of psychosocial content are reflected in Table 4.7 (b) and 4.7(c).

Table 4.7(a): College 2 (Formative and Summative Written Assessment)(N/S = not submitted)

MNS 100

Year reviewed (t=test)	Formative Assessment		Total mark	Final %	Exam/Deferred		Total mark	Final %
	Psychosocial care content	Physical care content			Psychosocial care	Physical care		
2004 N/S	-	-	-	-	0	100	100	0%
					0	100	100	0%
2005N/S	-	-	-	-	0	100	100	0%
					N/S	-	-	-
2006(2t)	0	100	100	0%	N/S	-	-	-
					N/S	-	-	-
2007 (5t)	0	250	250	0%	8	92	100	8%
					-	-	-	
2008 (3t)	26	124	150	17.3%	0	100	100	0%
					0	100	100	0%

MNS 200

Year reviewed (t=test)	Formative Assessment		Total mark	Final %	Exam/Deferred		Total mark	Final %
	Psychosocial care content	Physical care content			Psychosocial care	Physical care		
2004 N/S	-	-	-	-	-	-	-	-
					-	-	-	-
2005(1t)	0	50	50	0%	10	90	100	10%
					8	92	100	8%
2006(2t)	15	85	100	15%	18	82	100	18%
					N/S	-	-	-
2007 (3t)	12	138	150	8%	0	100	100	0%
					N/S	-	-	-
2008 N/S	-	-	-	-	1	99	100	1%
					10	90	100	10%

Table 4.7(b): College 2

MNS 100 summary

Year of Review	Tests	Exams
2004	N/S	0% (0/100)
2005	N/S	0% (0/100)
2006(2t)	0% (0/100)	N/S
2007(5t)	0% (0/250)	8% (8/100)
2008 (3t)	17.3% (26/150)	7% (7/100)

Table 4.7(c): College 2

MNS 200 summary

Year of Review	Tests	Exams
2004	N/S	N/S
2005 (1t)	0% (0/50)	10% (10/100)
2006(2t)	15% (15/100)	18% (18/100)
2007(3t)	8% (12/150)	0% (0/100)
2008	N/S	1% (1/100)

College 3 did not submit most of the tests and examination papers. The summary in Table 4.9 is based on the results of the few available records handed for review and as such, poseda limitation to the review.

Table 4.8(a): College 3 (Formative and Summative Written Assessment)(N/S= Not Submitted)

MNS 100

Year reviewed (t=test)	Formative Assessment		Total mark	%	Exam/ Deferred		Total mark	%
	Psychosocial care content	Physical care content			Psychosocial care	Physical care		
2004 (4t)	0	200	200		12	88	100	12%
					24	76	100	24%
2005 N/S	-	-	-	-	0	100	100	0%
					N/S	-	-	-
2006 (2t)	0	100	100	-	5	95	100	5%
					7	92	100	7%
2007 (4t)	2	198	200	-	N/S	-	-	-
					N/S	-	-	-
2008 N/S	-	-	-		N/S	-	-	-
					N/S	-	-	-

MNS 200

Year reviewed (t=test)	Formative Assessment		Total mark	%	Exam/ Deferred		Total mark	%
	Psychosocial care content	Physical care content			Psychosocial care	Physical care		
2004 (3t)	0	150	150		0	100	100	0%
					10	90	100	10%
2005N/S	-	-	-	-	-	-	-	-
					-	-	-	-
2006N/S	-	-	-	-	-	-	-	-
					-	-	-	-
2007 N/S	-	-	-		-	-	-	
					-	-	-	
2008 N/S					0	100	100	0%
					0	100	100	0%

Table 4.8(b): College 3

MNS 100 summary

Year of review	Tests	Exams
2004 (4t)	0% (0/200)	12% (12/100)
2005	N/S	0% (0/100)
2006(2t)	0% (0/100)	5% (5/100)
2007(4t)	1% (2/200)	N/S
2008	N/S	12% (12/100)

Table 4.8(c): College 3

MNS 200 summary

Year of review	Tests	Exams
2004(3t)	0% (0/50)	0% (0/100)
2005	N/S	N/S
2006	N/S	0% (0/100)
2007	N/S	N/S
2008	N/S	0% (0/100)

In conclusion, the percentage of psychosocial questions in tests and examination papers was not consistent inside years, year levels and across the three colleges ($p<0.001$) and are always significantly lower than suggested ratios by R425 which is 28.6%. Refer Table 4.9 and Table 4.1

Table 4.9: Psychosocial Content in Midwifery Tests and Examinations in the Three Colleges

Colleges	MNS 100	MNS 200
1	4%	0.7%
2	4.5%	8%
3	3.4%	0%

4.6.6 Register of Midwifery Cases

This is a register that every student midwife is required to complete in accordance with the Regulations of the South African Nursing Council (amended rules). It is a competency requirement that should be submitted to the South African Nursing Council as part of completion of training for the four year program in nursing. Table 4.10 displays the criteria to be met by the midwifery students regarding the register for midwives.

Table 4.10: Midwifery Education Register Requirements (REF.P95)

Skill/Procedure	Required number
1. Witnessed- normal deliveries	5
2. Witnessed-episiotomy	5
3. Perform and repair an episiotomy	1
4. Witness obstetric interventions	5
5. Abdominal palpations	50
6. Vaginal examinations	15
7. Vaginal deliveries	15
8. Postnatal care	25
9. Antenatal care	20

The focus of the register, as reflected within Table 4.10 is on the physical care of pregnancy. The latest modified register (REF.P95)does also not reflect any psychosocial component of midwifery care.

4.7 QUESTIONNAIRE RESPONSES FROM PREGNANT WOMEN

4.7.1 Introduction

As part of the quantitative phase of the study, self-administered questionnaires were distributed to pregnant women in three clinics in the Gauteng Province to establish their experience of psychosocial problems (Appendix S). Women were recruited from the clinics' waiting room.The women's antenatal cards were reviewed while the women completed questionnaires. The researcher and the assistant were on site to clarify the questionnaire.

With permission from the ALPHA Group (2005), the Antenatal Psychosocial Health Assessment (ALPHA) questionnaire was adopted and modified. (Department of Family and Community Medicine, University of Toronto (http://dfcm9.med.utoronto.ca/research/alpha))(Appendix H).

The final questionnaire consisted of thirty three closed-ended questions. The first two questions covered demographic data which included the age of the mother and the duration of pregnancy. The next six questions established the women's emotions and feelings regarding the pregnancy. Seven questions focused on social support and work environment. The last thirteen questions were about life events and experiences, and any history of mental illness.

The lower portion of the form was used to record psychosocial factors that were recorded on the antenatal card by the assessing midwife. On the lower part of the second page of the

questionnaire the women were also requested to write any other information that they wanted to share

4.7.2 Data Collection Process

The researcher reported to the manager of the antenatal clinic every morning before starting with the data collection. This was a matter of courtesy and also to ensure that the timing for distribution of questionnaires was right. Data collection occurred in the clinic waiting room and was generally done whilst the women were waiting for the midwives to attend to them. Priority was given to health information sessions if offered on that particular day. The purpose of data collection was explained to women prior to them signing an informed consent for voluntary participation before completing the questionnaire (Appendix I).

The researcher provided a pen with each questionnaire and a box for the return of the questionnaire. The participants were reminded of the voluntary nature of participation. They were further assured of anonymity and confidentiality and asked not to write their names or any other personal information on the questionnaire. They were further informed that their decision concerning participation would not affect their care and they could withdraw from the study at any time. The questionnaire was formulated in English. An assistant accompanied the researcher for recording of data with an added purpose of assisting with the clarification through other African languages for women who did not understand English. The estimated completion time for the questionnaire was 15 minutes. The researcher and assistant stayed in the waiting room until questionnaires were returned.

4.7.3 Results

Three-hundred-twentyquestionnaires were distributed and 302 completed questionnaires were returned.

The mean age as reflected on Table 4.11 was 26 years which is an acceptable childbearing age. The minimum age was 16 years and the maximum 43 years, with a standard deviation of 5,5. A pregnancy occurring at the age of sixteen years is considered a teenage pregnancy.A pregnant child of 16 years of age or lessis psychosocially at risk as the pregnancy may be unplanned and/or unwanted whereasat 43 a woman may be at risk for similar reasons but also on account of the increased likelihood of chromosomal abnormality, as the maximum childbearingage is 35 years.

The duration of pregnancy at the time of enrolment ranged between 12 and 41 weeks, with a mean of 30 weeks and a standard deviation of 6,6. At 30 weeks the women were approaching the end of the second trimester of pregnancy at which time they would likely have formed an opinion of antenatal care and be able to share their experiences.

Table 4.11: Age and Duration of Pregnancy

Variable	Number (n)	Mean/±SD	Range
Age (years)	296	26/5.6	16-43
Duration of pregnancy (weeks)	286	30.7/6.6	12-41

4.7.3.1 **Feelings and emotions**

The women's emotional status during the current pregnancy is reflected in Figure 4.1.

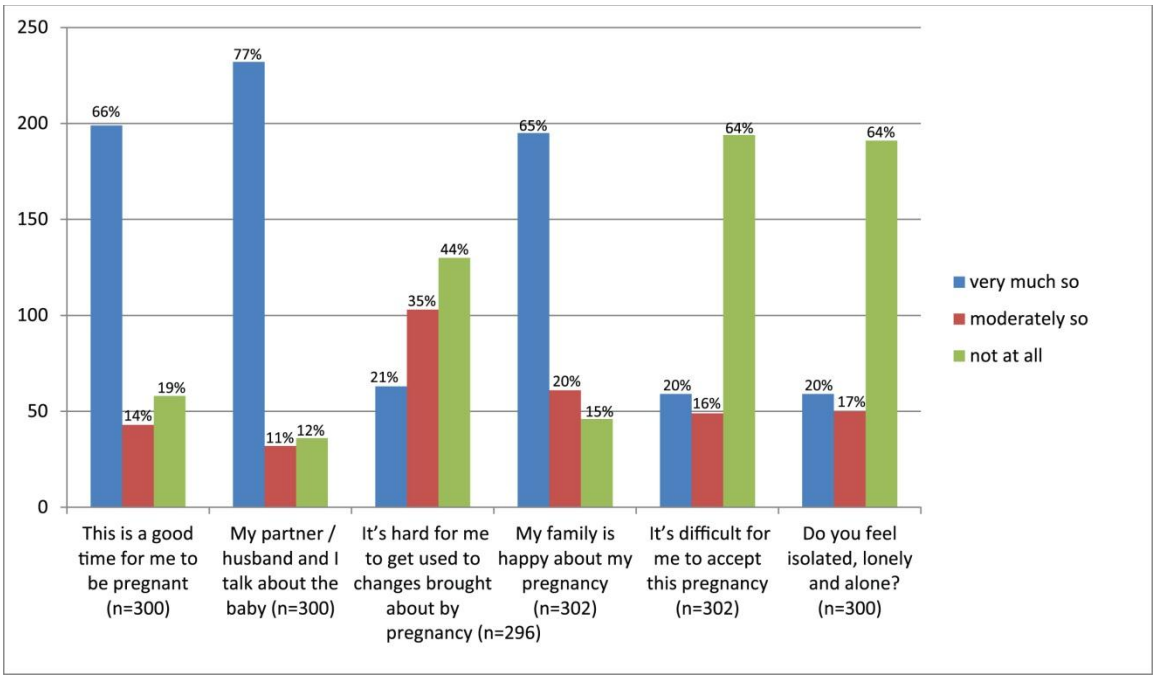

Figure 4.1: The Women's Feelings and Emotions

Most of the participants (66%) agreed that the timing for the pregnancy was appropriate, they were able to discussthe pregnancy with partners (77%) and their families were happy about the pregnancy (65%).

Slightly more than half of participants, (56%) had difficulty in adjusting to the changes brought about by pregnancy. This may have been due to lack of health information given to women by midwives regarding pregnancy,as revealed subsequently during focus group

discussions.Furthermore, 20% of women found it hard to accept the pregnancy. Possibly related to non-ideal timing of the pregnancy which was also reported by 20% of participants, 20% expressed that they felt very lonely and 17% felt moderately lonely.

In 2000, the American College of Obstetricians and Gynecologists (ACOG), in addressing psychosocial screening in pregnant women, stated that having an unintended pregnancy may be a predictor of poor antenatal attendance and these women are more likely to smoke and drink during pregnancy with an increased risk for the woman being battered or abused. As reflected in this study, women with an unintended pregnancy tended to come to terms with the situation, however, they needed to be psychosocially supported.

4.7.3.2 **Social support and work environment**

A minority of respondents (19%)indicated that they had no social support. More than 50% of the sample stated that they did not have access to transport which could be one factor that keeps them from attending clinic appointments. The Perinatal Mental Health Report (2011),indicates that 69% of pregnant women lack partner support whereas 39% have an unsupportive family. Lack of social support might lead to loneliness, emotional isolation and feelings of distress for the women, and ultimately mental illhealth. Lack of transport could also lead to a delay in seeking medical attention with the onset of labour, which could also lead to further complications. There was a 29% indication that either the woman or her partner used alcohol, tobacco or drugs that could pose a risk to foetal wellbeing(refer to Figure 4.2).

The highest percentage (97%) indicated that they were not exposed to chemicals at work, the main factor behind this score being that most women reported that they were unemployed. On balance (excluding the transport and telephone access issues), ± 16% of respondents were at risk because of the revealed lack of social support.

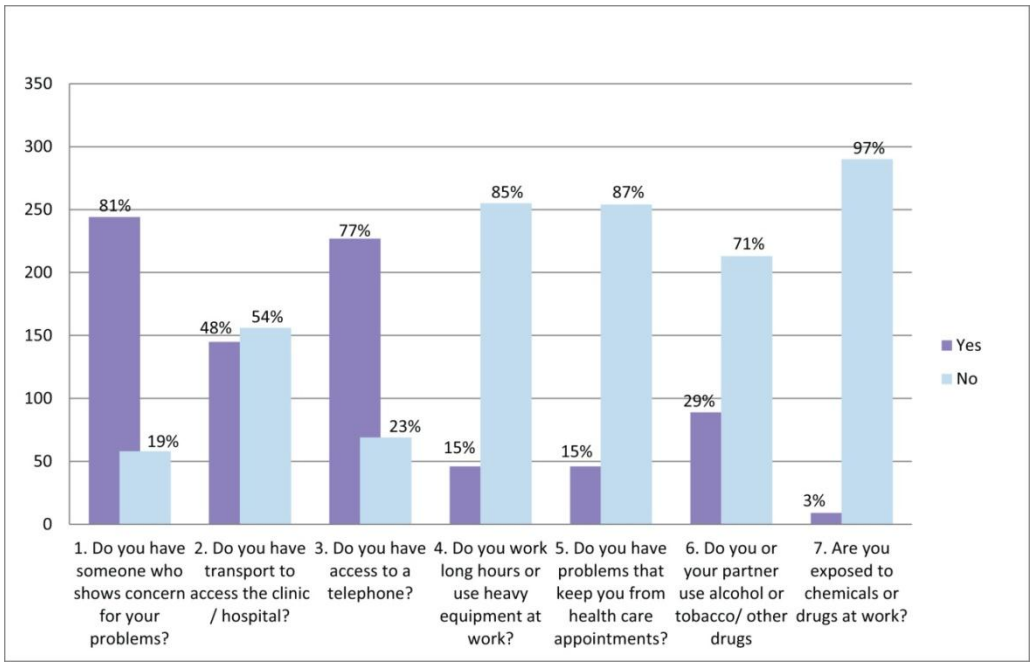

Figure 4.2: Social Support and Work Environment (*n*=302)

4.7.3.3 Family violence

The women's experiences of family violence revealed that some women were exposed to various forms of physical, emotional and sexual abuse as reflected inFigure 4.3.

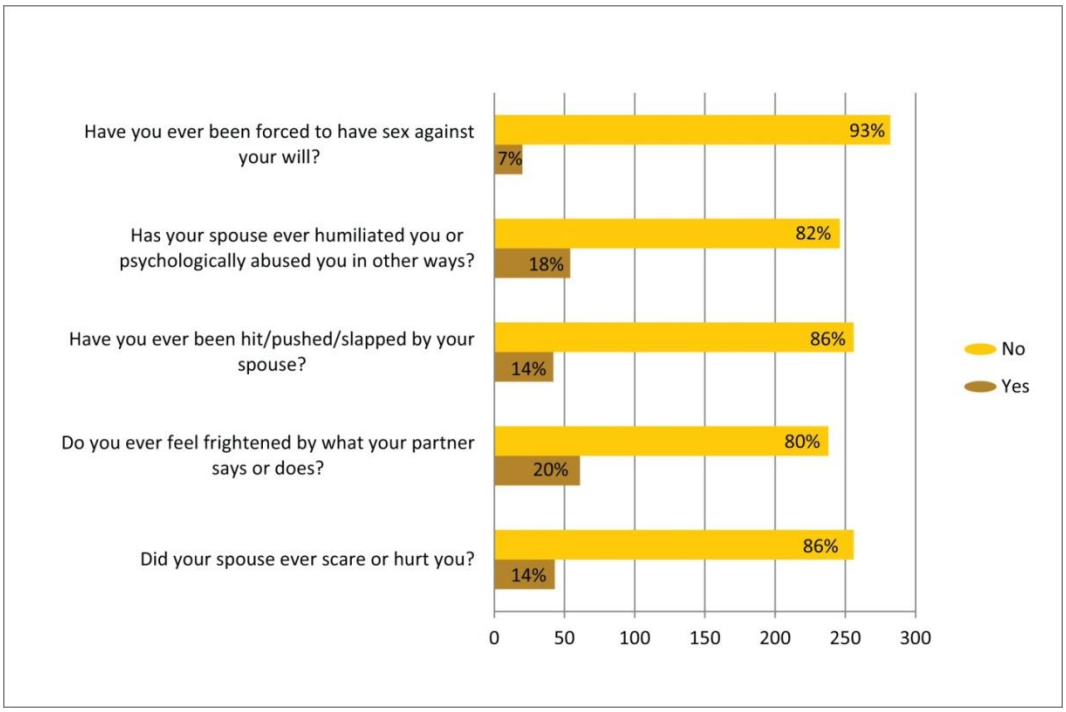

Figure 4.3: Women's Experiencesof Family Violence (*n*=300)

4.7.3.4 **Stressful life events**

The response from 300 participants was that 184 (61.3%) were experiencing stressful life events during the current pregnancy, whereas 116 (38.6%) did not experience any stressful life events. Amongst those who experienced stressful life events, 72 (24%) experienced two events and 44 (14%), experienced three or more stressful life events. This provides evidence of the importance of assessing women psychosocially as almost all women present with psychosocial problems. The specific life events experienced by participants are reflected in Table 4.12.

Table 4.12: Stressful Life Events Experienced by Respondents during the Current Pregnancy

Stressful life events	Women's responses n (%)	
	Yes	no
1.1 Have you experienced death of a spouse or family member?	82(27)	218(73)
1.2 Have you gone through a divorce or marital separation?	26(9)	274(91)
1.3 Were you retrenched or fired from work?	37(12)	264(88)
1.4 Have you been a victim of rape or sexual assault?	15(5)	286(95)
1.5 Have you ever experienced any pregnancy loss?	60(20)	242(80)
2. Was the pregnancy planned?	140(46)	162(54)
3. Have you been sick during this pregnancy?	141(47)	160(53)
If yes, what was the illness?	See response to this question below	
4. Have you ever attempted suicide?	15(5)	285(95)
5. Have you ever been diagnosed with a mental health condition?	14(5)	286(95)
6. Have you been hospitalised for a mental health problem?	16(5)	284(95)
7. Did you attend any mental health counselling session?	27(9)	274(91)

Women experienced stressful life events to a certain extent as reflected in Table 4.12.More than half (54%) indicated that their pregnancies were unplanned, which is interesting in light of the 66% of participants who responded that it was a good time for them to be pregnant. This suggests that unplanned pregnancies may be welcomed or at least accepted by many women.Five percent of respondents experienced mental ill-health, with an indication of being suicidal, being hospitalized or attending mental health counseling.

For the 47% of participants who were ill during their pregnancy, the frequency of the conditions that were indicated were influenza (19), nausea and vomiting (17), headache (12), abdominal pain (10), diarrhoea or stomach ache (10),backache (6), 7 were infected with HIV (one of whom was diagnosed with tuberculosis,vaginal bleeding (3), anemia (2), asthma (2)and syphilis (1). Other women experiencedminordisorders of pregnancy such as heartburn, painful

gums, dizziness, leg cramps and excessive vaginal discharge. One woman cited “stress” as the illness that she experienced during her current pregnancy. The conditions reported by women were mostly physical, which might imply ignorance of psychosocial problems.

4.7.4 **Women’s Personal Experiences with Antenatal Care**

Some of the additional information written on the questionnaire in response to the open-ended questionsby some women were:

“*Thank you for your project, I think us people from outside South Africa we experience problems with doctors. Most of us get stillborns because when you are in labour you fear coming to clinic early not wanting to get that bad treatments, being called names not attended by anyone, some deliver on benches because of being foreigners”.* (This response confirms the information subsequently received from all the focus group interviews where even South African women were concerned about the discrimination that is displayed by midwives against foreign women).

Another woman said *“The service is excellent, nurses are friendly and helpful. The only problem I have experienced is that even if you come late with 5 minutes they send you back home, irrespective of circumstances or even bother to ask you why are you late, to be late is better than not tocome at all. To assist one person who is late by 5 minutes is not thewhole day*”. (Women from the focus group were also concerned about punctuality of the service offered. The practice is that they have to arrive at the same time and before midwives initiate the antenatal care service otherwise they are turned away).

4.8 **THE REVIEW OF ANTENATAL CARDS**

The review of antenatal cards was done simultaneously with the distribution of self-administered questionnaires for pregnant women at the three clinics chosen for the study. Although there was no formal guideline, midwives clearly attempted to assess the women psychosocially and only two antenatal cards out of 302 did not reflect any social or psychosocial factors. The finding was that the focus of assessment was on social factors as reflected in Table 4.13. The possible reason for the lack of psychological assessment could be the lack of guidelines for psychosocial assessment and psychosocial care. The social factors recorded included availability of a support system for the woman, marital status and employment status. Most women were single and unemployed.

The following social factors that were recorded by midwives were identified from the antenatal cards. The frequency of social factors ranged between one to three social problems for each woman.

Table 4.13: Psychosocial Issues Recorded on Antenatal Cards

Social factor	Number recorded on the antenatal card (n=302)
Single parenthood	68
Unemployed	57
Drinker	7
Smoker	4
Self support	6
Partner supportive	24
Staying with boyfriend	19
Spouse dead / widow	2
Teenage pregnancy (women younger than 18 years)	2
Students/scholar	7
Requested termination of pregnancy (TOP)	2
HIV/AIDS positive	63
Nothing recorded on card	2

HIV/AIDS reflected in 63 of the reviewed antenatal cards, which is 20,8%. Freeman et al (2008) and Herman et al (2009), as cited by the Perinatal Mental Health Report (2011), stated that almost all people living with HIV/AIDS in South Africa have a diagnosable post-traumatic stress, which is higher than the prevalence for other mental health disorders which accounts for 30,3%.

4.9 MIDWIVES' SURVEY RESULTS

4.9.1 Data Collection Process

A two page self administered questionnaire was distributed to gather information from a representative sample of midwives from the nine provinces in South Africa. The aim was to determine their perceptions of psychosocial care during pregnancy. The midwives were attending the 8th Annual Congress of Midwives of South Africa at which the researcher was presenting a paper. A special letter requesting permission for data collection was written to the congress organizers and permission was granted (Appendix J).

The questionnaire consisted of four closed ended and five open ended questions (AppendixL). The open-ended questions allowed midwives to express their points of view and experiences regarding psychosocial care during pregnancy.The questionnaire gathered demographic data regarding the respondents' province where they practiced midwifery, their duration of midwifery practice and area of practice. It furtherestablished the type of psychosocial problems that midwives encountered during their practice, the extent of the implementation of psychosocial care, their personal experiences and the interventions once a psychosocial problem had been identified.

A questionnaire was placed on each delegate's seat in a hall at the beginning of presentations. Participants were asked to return the completed questionnaires to a display box at the conference display booth (Appendix K).Among approximately 500 attendees, 232 completed questionnaires were returned.Those who completed the questionnaire were entered into a draw for a gift. Data were captured in a database using Stata Release 10 statistical software package.

4.9.2 Geographic Distribution of Respondents

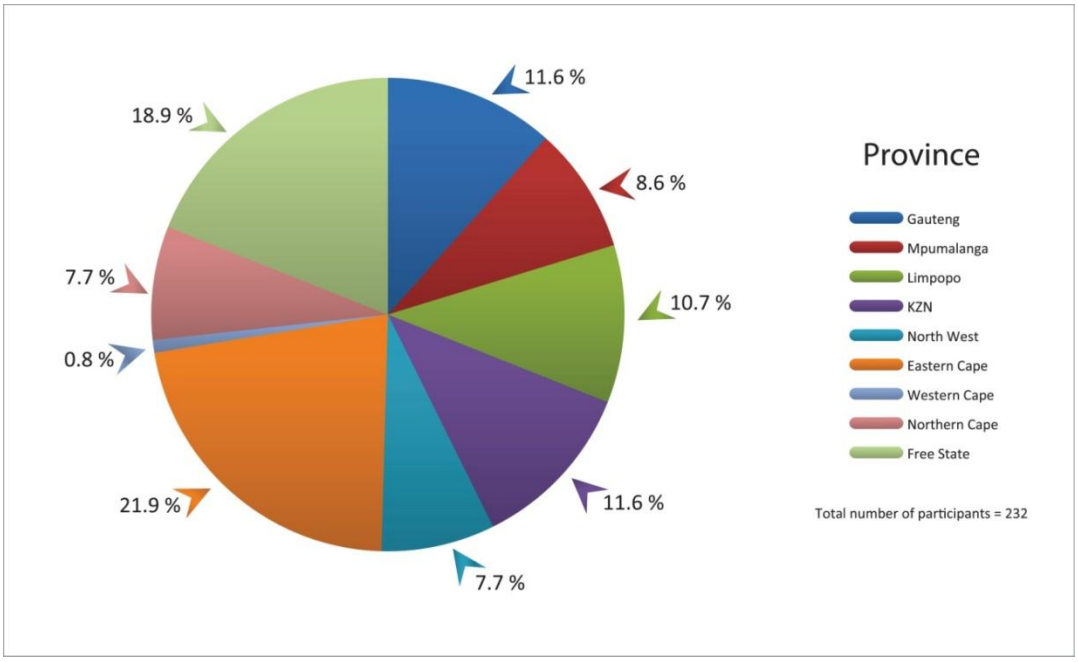

Figure 4.4: Geographic Distribution of Respondents

Most respondents came from Eastern Cape Province (21.9%) and Free State (18.9%). The higher number of attendees from the Eastern Cape and the Free State reflects the fact that the congress, which rotates between provinces ona yearly basis, was held in the Free State

in2009 and the Eastern Cape is nearest to Free State. All provinces seemed to be reasonably represented except the Western Cape at 0.8%.

Representation could also be other than reflected in Figure 4.4 as the respondents to the questionnaire represented ±46% of attendees. The possibility is that only those respondents who were interested in psychosocial care filled in the questionnaire. The researcher's presentation on psychosocial care which was given before the return of questionnaires might also have affected the response rate either positively or negatively. The incentive of being entered into a draw to win a gift might also have affected participation, but representation was generally reasonable.

4.9.3 The Respondents'Experience in Midwifery Practice

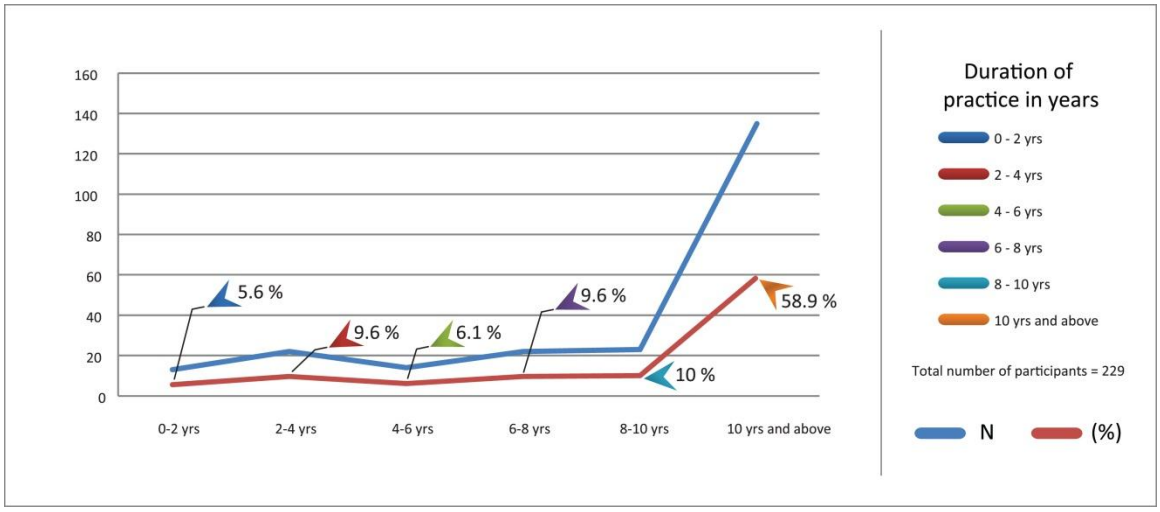

Figure 4.5: The Respondents' Duration of Practice in Midwifery Care

4.9.3.1 Duration of midwifery practice

Among 229 participants who provided information on their experience of midwifery practice, more than half (58.9%) had practiced for 10 years or more and only 5.6% practiced for less than 2 years.Those who had practiced for more than 8 years (which represents long service that could provide one with reasonable experience)added up to 68.9%. This implies that most of the respondents were quite experienced in providing midwifery care tochild-bearingwomen.Based on the midwives' long service, they would be able to share the experiences of psychosocial care**.**

4.9.4 The Respondents' Area of Work within Midwifery Departments

Regarding work experience, as reflected by Figure4.6, 43.4%had workedfor longer in the labour ward than in any other maternity areas.This is an area where support is important as women are highly anxious and probably stressed due to labour as characterised by uterine contractions and the anticipation of the birth of the baby. Furthermore, 10.4% of respondents had worked in the three midwifery areas and 11.3% had worked in all four areas, that is the antenatal clinic, labour ward, postpartum ward and neonatal ward.

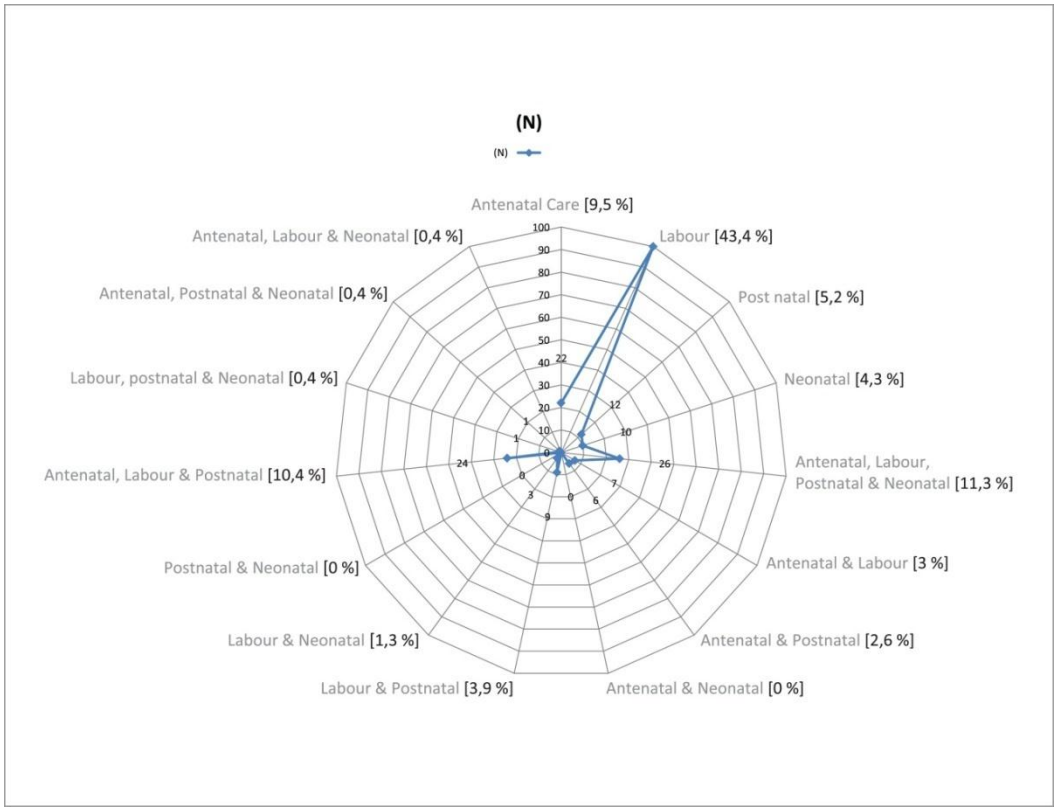

Figure 4.6: Graphic Illustration of the Respondents' Area of Work within Various Midwifery Departments

Twenty two respondents (9.5%) practiced exclusively in the antenatal unit where antenatal care is offered to pregnant women. Antenatal care is the focus of the study as it is ideal to assess the woman psychosocially during the antenatal period in order to prepare her for labour and parenthood. However, the experience thatrespondents had in the labour ward (43.4%) added to (9.5%) that had an experience in the antenatal unit give us 53% of midwives who should be able to share their perceptions of psychosocial assessment and psychosocial care during pregnancy.

4.9.5 Psychosocial Risks Encountered by Respondents

The common psychological and social problems that the midwives encountered were quite numerous, with teenage pregnancy, HIV/AIDS and poverty being the highest. Table 4.14 illustrates psychosocial problems that were prevalent.

The social factors rated higher with an indication of teenage pregnancy (n=56), HIV and AIDS (54) and poverty (42). A teenage pregnancy is defined by WHO (2004) as a pregnancy in a woman aged 10-19 years at the time when her baby is born. Furthermore, WHO states that teenagers mostly have sexual relations with older men, which puts them at risk of sexually transmitted diseases, especially HIV infection.Teenage pregnancy carries both physiological and psychosocial risks. Ireland (2009)stated that “the statistics for teenage pregnancy is scary”. Data from the Health Systems Trust website show an increase in teenage pregnancy in South Africa from 14.1% in 1991 to 39% in 2006.

Poverty is associated with an inability to manage the pregnancy as there could beno finance available which often leads to non-compliance and babies born before arrival at the clinic. Lack of readiness for parenthood as a result of an unplanned, unintended, unaccepted or unwanted pregnancy and other factors like poverty are likely tolead to maternal stress. The women might also not be ready for parenting. Options like adoption and termination of pregnancy should be clearly explained to the woman in need.

The existence ofmedical conditions like HIV, diabetes and hypertension increases the risk of psychosocial problems. HIV/AIDS is a major concern, with 23.2% midwives indicating that this is an issue they encountered in practice. Psychosocial factors related to HIV/AIDS include:women refusing voluntary counseling and testing, non-acceptance of positive status, non-compliance with anti-retroviral regimens andunwillingness to disclose to partner due to fear of rejection.

The World Health Organization(2003) recommendsthat personal beliefs, values assumptions and the attitudes of health care workers regarding HIV and AIDS should be taken into consideration as there is evidence suggesting that the attitude of health workers can have beneficial or detrimental effects on people accessing HIV testing. WHO further recommends workshops on values clarification to help health workers to move beyond self-awareness toward attitudinal change, to avoid their fear and stigma, to avoid communicating fear, stigma and discrimination, all of which usually deter people from accessing testing and other support

services and these will help women to overcome their fear and the effects of stigma and discrimination.

There is a need for a further research regarding psychosocial support specifically for women who are HIV positive. This could be facilitated through the Midwives' AIDSAlliance. The Alliance recommendation from the survey they conducted on midwives' perspectives of HIV/AIDS care in maternal services, is that, simple functions like HIV testing can be done by other health care workers so that midwives are free to do other complex consultations with women, which seemingly, even not specified, includes psychosocial risk assessment, which is a generally understood recommendation (Midwives AIDS Alliance, 2008).

Difficulty in communicating with the woman often occurs due to language barriers e.g. in dealing with foreigners, women with speech and or hearing disabilities, women who communicate through sign language, and those with an inability to read and write, thereby denying access to health information from brochures, posters and charts.Communication is a basic and an essential part of every contact undertaken with women, yet it is something that midwives underplay and seldom view as a priority intervention to improve interpersonal relationships.

Lack of support by the woman's spouse or an absent spouse occurs mainly when pregnancy is unintended and unaccepted, when the partner is committed to another woman, with separation or divorce or death of a spouse. Social problems encounteredby midwives are listed in Table 4.14**.**

Table 4.14: Psychosocial Risks and Psychosocial Resource-Related Factors Encountered by Midwives

Social	Psychological	Resource related
▪ Teenage pregnancy (56) ▪ HIV/AIDS (54) ▪ Poverty (42) ▪ Unemployment (35) ▪ Lack of support by spouse or parents (35) ▪ Unplanned pregnancy (25) ▪ Attitude of women (15) ▪ Single parenthood (11) ▪ Disability/physically challenged (10) ▪ Medical problems (10) ▪ Planned to abandon or give up baby for adoption (8) ▪ Unbooked or late booking for antenatal (8) ▪ Genetic disorders (7) ▪ Alcohol, smoking and drug abuse (7) ▪ Communication/language barrier (5) ▪ Lack of knowledge (5) ▪ Prisoner (1) ▪ Hostile attitude of midwife (4) ▪ Migration / foreigners (4) ▪ Spouse's death during pregnancy (3)	▪ Depression (32) ▪ Unaccepted or unwanted pregnancy (30) ▪ Fear of the unknown (28) ▪ Emotional abuse and anger (23) ▪ Previous neonatal deaths, miscarriages and abortion, stillbirths (18) ▪ Anxiety (17) ▪ Rape / incest (17) ▪ History of mental illness or poor mental status (11) ▪ Sexual abuse (11) ▪ Pueperal psychosis (3)	▪ Lack of resources e.g social workers, formula feeds for HIV positive neonates (9) ▪ Staff shortage (6) ▪ Non-supportive leadership (5)

The psychological factors that were encountered rated second to social factors.These include a bad obstetric history, for example a previous neonatal death. Previous miscarriages and abortion or stillbirth often led to fear and anxiety regarding the next delivery. Also encountered were ahistory of mental ill-health, poor mental status or existing depression and pueperal psychosis (19.8%), fear of the unknown and anxiety (19.3%), a history of sexual abuse, rape and incest (12.9%) emotional abuse and anger (9.9%) and a history of neonatal deaths, miscarriages and or stillbirths (7.7%).

If psychosocial assessment is not conducted during antenatal care, mental illness or poor mental status could be missed**.** If women are not psychosocially prepared during antenatal care they may present with a high level of anxiety. The midwives' attitude might also contribute to the women's fear and anxiety.

Service delivery is also challenged by lack of resources, for example lack of social services. Formula feeds for HIV-positive neonates and anti retroviral drugs are often out of stock. Staff shortages do not allow for proper management of the women or for continuity of care.

4.9.6 **Midwives' Interventions**

Midwives indicated several actions that they took once a psychosocial problem was identified. Each midwife indicated more than one intervention as reflected in Figure 4.7. Although not clearly explained, comprehensive management seemed to be an intervention of choice (*n*=96). Management was multidisciplinary as they involved other health care providers in the management of pregnancy. "Managing accordingly" was further clarified by 72(31.4%) who referred the women to the social worker for further management.

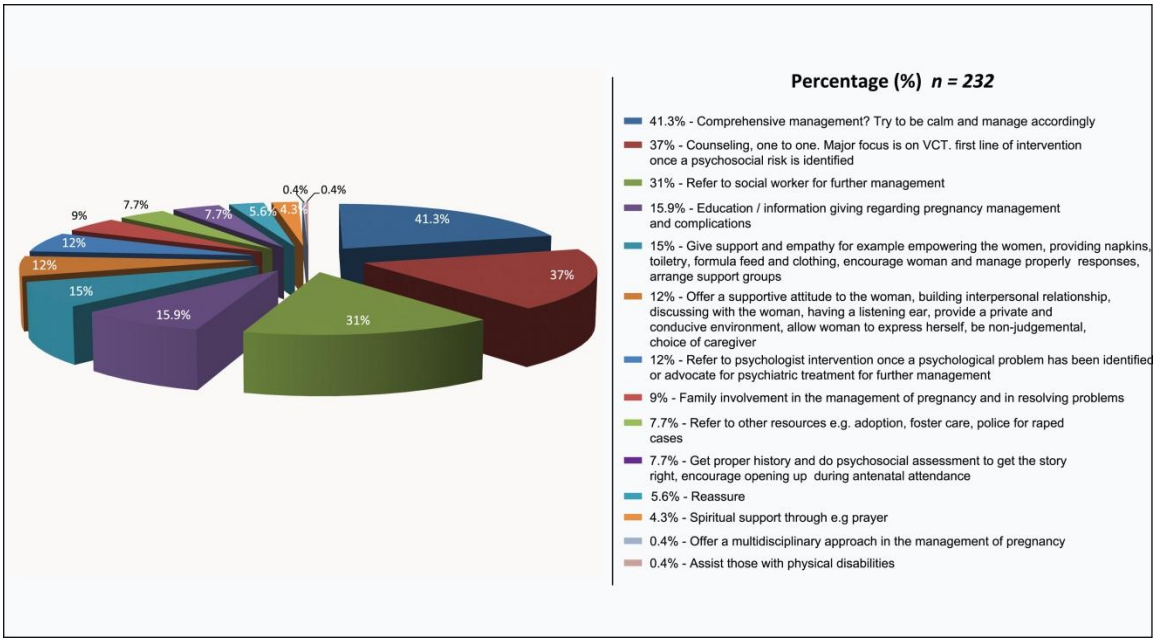

Figure: 4.7: Interventions Implemented by Midwives Once a Psychosocial Risk was identified

Twenty-eight midwives (12.2%) referred women for psychological intervention once a psychological problem was identified, or advocated for psychiatric treatment for further management. Furthermore,7.8% of midwives referred women for adoption and foster care options, and referred them to the police for reporting of rape.

Assessment as part of "managing accordingly" was important for the midwives to assist them to design a plan of care.Sixteen midwives (6.9%), indicated the importance of getting a proper history and doing psychosocial assessment to get the story right to encourage antenatal attendance andto help the woman to open up when giving history.

Counseling was also a major intervention amongst respondents (*n*=86), although the focus was primarily that of voluntary counseling and testing for HIV (VCT).The activities that were cited by midwives regarding counseling were, for example, giving the women health information regarding pregnancy management and possible complications 37(16.1%), and some form of reassurance13(5.6%).

Midwives offered women spiritual support through prayer when requested, engaged in discussions with women, listened to them, provided a private and conducive environment, and through being non-judgemental allowed women to express themselves (10.9%). Offering support to women and maintaining interpersonal relationshipshave been shown to encourage interaction between the midwife and the woman.This was reported by only 1.3% of midwives.

Regarding social care, women were given support and empathic gestures for example empowering the women through information, providing napkins, toiletry, formula feed and clothing. The women's families were also involved in the management of pregnancy and in resolving problems through health information (9.1%). Other interventions can be reviewed from Figure 4.7.

4.9.7 The Practice of Psychosocial Care during Pregnancy

The participants' responses to the question of whether psychosocial care was offered to women during antenatal care revealed that psychosocial care is offered adequately by (71), moderately by (117) and not at all by (33). Almost two-thirds of respondents(150;65.5%) confirmed that psychological care is inadequate. The results reflected in Figure 4.8, would depend on the respondents' understanding of the concepts"adequate" and "moderate".

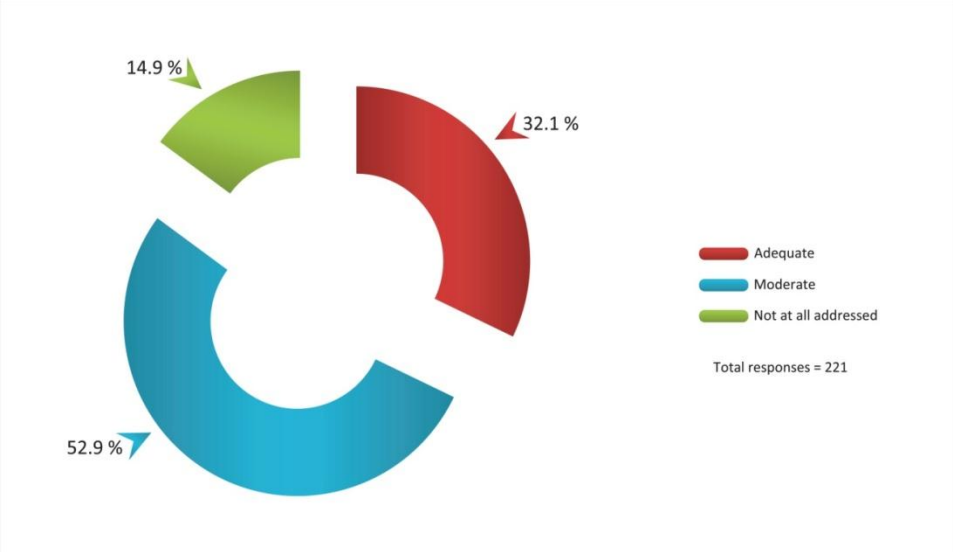

Figure 4.8: The Midwives' Perceptions Regarding the Implementation of Psychosocial Risk Assessment and Support during Pregnancy

The respondents who indicated that psychosocial assessment and care was moderately offeredor not practised at all,referred to the following as contributory factors:
Ignorance by midwives, focus/emphasis is only on pregnancy, routine care, having "a job to be done" approach and a lack of midwives' understanding of the importance of a holistic approach in managing pregnant women. Further reasons cited included: no specific format available to guide the midwife in addressing this issue, no indication on the antenatal card for psychosocial care, and lack of in-service training. Also included were inadequate resources,for example transport and psychologists for referral, shortage of staff, work overload (as midwives sometimes have to do administrative work), and the increased number of pregnant womenand girls attending clinics, specifically teenage pregnancies.

The respondents also cited the lack of professionalism displayed by doctors and health care workers which might lead to tension in interpersonal relations resulting in the women not sharing their problems. Cultural and language barriers were also cited as disturbing factors.

4.9.8 TheShortage of Midwives

The response regarding the availabilityof midwives seems to be a widespread concern from almost all provinces, as reflected in Table 4.15 and supporting literature. The frequency of staff shortages was based on the provincial representation as presented in Figure 4.4.

Table 4.15: TheShortage of Midwives within Represented Provinces

Province	Midwives' Representation (%)	Shortage of Midwives (%)
Eastern Cape	21.9	17.6
Free State	18.9	16
Gauteng	11.6	7.4
KZN	11.6	18.5
Limpopo	10.7	4
Mpumalanga	8.6	30
North West	7.7	27.7
Northern Cape	7.7	33
Western Cape	0.8	0

A shortage of qualified midwives appearsto be an international problem for example in an attempt to highlight staff shortages, viewpoints expressed by focus group in the Framework For Maternity Services in Scotland (2007), were as follows: "*You need more staff, you need more time. Midwives especially are key workers. If they run the busy antenatal clinic and see 50 ladies at once, they don't have the time to sit down and talk to each individual woman. If somebody's got a crisis, they do their best"*

4.9.9 Midwifery Education and Training in Psychosocial Care

The role of the midwife regarding psychosocial care seems unclear or poorly understood during the training of midwives. A follow up question on whether and to what an extent psychosocial assessment and psychosocial care were included within midwiferyeducation, elicited the responses shown in Figure 4.9.

One hundred-ninety-six midwives, 83% indicated that they were never taught psychosocial care during their midwifery training. Thirty six (15.5%) were taught but to a very limited extent, citing for example that the four year course was very congested.

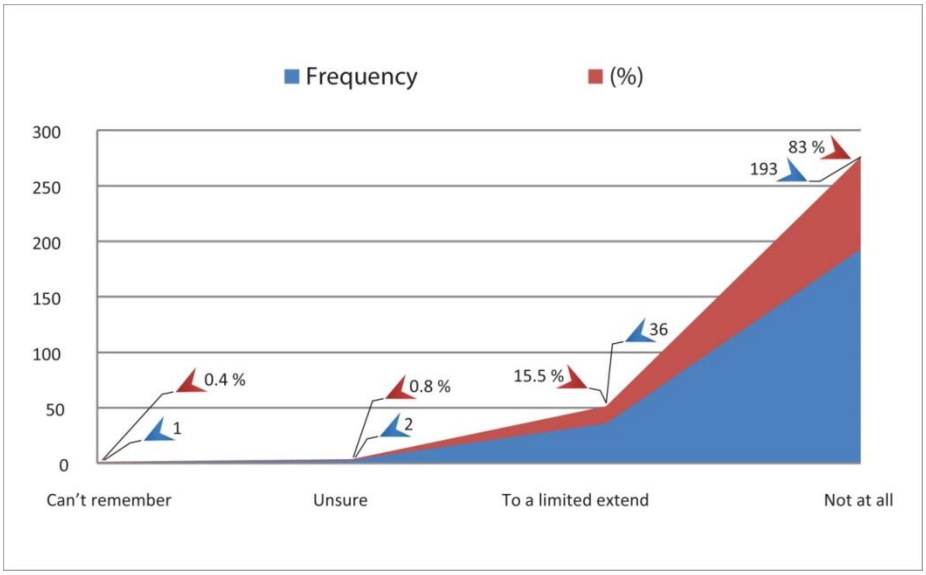

Figure 4.9: The Extent of Psychosocial Care in Midwifery Education (*n*=232)

One respondent indicated that even during her Advanced Midwifery training, psychosocial care was not addressed. There is a clear indication from Figure 4.9 that the psychosocial content of midwifery education and training is addressed to a very limited extent based on the following responses: not at all (83%), limited extent (15,5%).Other respondents (0,4%) could not remember whether psychosocial care was part of training.

For those that indicated that psychosocial care was addressed to a limited extent during their midwifery education and training, the following were some of the psychosocial factors that were taught: counseling and emotional support for the pregnant woman; abuse; poverty; unemployment; genetic disorders and disability; teenage pregnancy; culture sensitivity; alcohol and drug abuse; puerperal psychosis. These are important psychosocial factors that can put women at risk of psychosocial complications. Furthermore, 7% of respondents cited "holistic care" as having been addressed theoretically.

4.9.10 Midwives' Personal Experience of Psychosocial Care

With regard to the midwives' personal experiences of psychosocial care during their childbirth, only 9 out of 178 respondents indicated that their psychosocial needs were met. Fifty four participants (32,5%) did not respond to this question, the reason might be that it was a sensitive question that probed their personal lives, or that their psychosocial needs were not met asreflected by169 participants (94.9%) who indicated that their needs were not met.

The following were sharedas some of their experiences relating to whether their psychosocial needs were met or not:

"*I was only supported by my husband",*
"I used a private midwife, family was there for me",
"Because people who delivered me knew me, as I was a trained midwife, I was supported by colleagues",
"Nothing explained except being scolded, none, everything was a surprise, nothing was explained to me, I was a teenager at 16 years",
"A touch and go type of care, midwives were unapproachable, attitude of midwives was not good, afraid to talk to her",
"They were avoiding me deliberately as they knew I was a midwife",
"No, husband was not even allowed in the labour ward",
"Spouse was denying the pregnancy, as such was reluctant to support me",
"Because I insisted on talking and demanded some explanations and some services as I was a trained midwife"

The respondents' comments provide evidence that psychosocial assessment and care is lacking within midwifery care.

4.10 CONCLUSION

This chapter presented quantitative results based on record reviews and data obtained through questionnaires

. The SANC regulations, the midwifery curriculum for the three colleges, the learning guides and the Gauteng antenatal care policy broadly state psychosocial care as reflected in the emphasis on "holistic care". The women's responses to questionnaires, the records in their antenatal cards and the midwives' responses suggest that psychosocial problems do exist during pregnancy and that there is a need for psychosocial support.

The psychosocial content in midwifery education is scanty as it focuses on teenage pregnancy and puerperal psychological disorders. The clinical tools used for clinical practice for student midwives reflect psychosocial care to a limited extent.

Chapter five presents qualitative findings.

CHAPTER 5

5. THE DESCRIPTION AND ANALYSIS OF QUALITATIVE FINDINGS

5.1 INTRODUCTION

Chapter five presents and discusses the qualitative findings as part of a mixed-method study. The findings were obtained from multiple data sources. Focus group discussions were conducted with pregnant women and midwives from the three first level midwifery-led clinics offering antenatal care. Within-group and across group data saturation occurred with both the midwives and the women's interviews. Data were further obtained through individual in-depth interviews with midwifery experts and informational redundancy occurred with the fourth interviewee.

Three clinics offering antenatal care were observed during data collection. The main source of data was from recorded interviews. Unstructured observation of the environment and the process of antenatal care were done by the researcher. Informal conversations with either midwives or pregnant women occurred spontaneously as pregnant women often had issues to share and sought assistance.

The general approach to qualitative data analysis was based on Onwuegbuzie and Teddlie's seven stage conceptualization process (2003). The seven stages are: data reduction, data display, data transformation, data correlation, data consolidation, data comparison and data integration.

5.2 UNSTRUCTURED OBSERVATIONS

Unstructured observation and informal conversations also served as sources of data. These unstructured observation findings and some of the informal conversations shared with pregnant women are discussed in this chapter. For the purpose of identification, the clinics are coded as G1, G2 and G3. The physical structure of the clinic, the environment and the process of antenatal care for each clinic are discussed.

5.2.1 **Clinic G1**

The clinic structure and environment

The space for attending to the pregnant women during antenatal care was reasonable, encompassing a reception room accommodating ±100 women. This is the area where women are sorted andreferred to different procedures of routine antenatal care, for examplefirst visit booking, vital data monitoring or follow up visits. Health information sessions and antenatal exercises are held in this room. The room is well ventilated, spacious and allows for socialization amongst women.

There are five consulting rooms, a sluice room for urinalysis, a blood collection room and a tea room for staff. There is also an area for conducting voluntary counseling and testing (VCT), which is also used as a reception area for postnatal care and a well baby clinic. There is an ablution area. Generally the space caters adequately for pregnant women, even to the point of ensuring privacy and confidentiality during consultations.

The process of antenatal care

The antenatal clinic is run daily from Monday to Friday. Women arrive as early as ten-to-six in the morning. Midwives arrive at half-past-seven. Women are assigned to receive different interventions, i.e. as first or follow-up visits. Those for first bookings are booked and sent to the VCT room. VCT is offered in a group format. During the process of booking, women are either given health information or attend antenatal exercises which are mostly offered by nursing students from the affiliated University.

After VCT, women booking for first visit go for routine blood tests, urinalysis and blood pressure monitoring. They are then weighed and sent to consulting rooms for abdominal examination and monitoring of foetal wellbeing. The follow-up visits are further screened for those who require repeat blood tests. Women are also weighed and then sent for abdominal examination. The process takes approximately three hours for each woman. A cross-sectional study by Menon, et al in Zambia in 2010 on the perception of women regarding community antenatal care, showed that the mean waiting time was 3,6 hours, with a range of 1 to 6 hours, which is more or less the same as the waiting period in this study.

5.2.2 **Clinic G2**

The clinic structure and environment

This clinic is very congested with a narrow passage. There are four consultation rooms, a staff room, an administration corner, and a small waiting room that only accommodates thirty chairs with no free movement between the chairs. The general environment was often not clean. However, there were several very informative posters on the waiting room wall, addressing most aspects pertaining to antenatal care and labour.

The process of antenatal care

Follow-up antenatal care is offered routinely on Mondays, Tuesdays and Fridays, and first visits are on Wednesdays and Thursdays. Only twelve women are booked for Wednesdays and Thursday each week. Women arrive at the clinic at around half-past-seven and the administration office releases files between half-past-seven and eight. Health information sessions are offered from eight. Women then go for routine observations and an abdominal examination. The whole antenatal care process lasts ± three hours. The process is very task-oriented.

5.2.3 **Clinic G3**

The clinic structure and environment

The antenatal clinic is situated within the primary health care/curative setting. The area is congested and women are squashed into a ±10sqm corner. There is limited privacy. There are two consulting rooms for antenatal care, a blood collection room and a sluice room.

The process of antenatal care

The clinic offers services from Monday to Friday except for Wednesday which is also specifically for postnatal care. First bookings are attended to first as the blood specimens must be ready for dispatch by 10am. Women for follow up visits are attended to at a later stage. This system might compromise regular antenatal attendance as their follow up visits are not attended to earlier. All women arrive at around seven in the morning but do not have specific times to be attended to and sometimes they wait until three in the afternoon.

On the first day of data collection, the researcher left the clinic at half-past-elevenwith women not yet attended to and routine vital data monitoring not yet done. Two of the women went up to the labour ward office to enquire about the availability of any midwife to assist; one woman went home indicating that she only came for blood results, as such, she would return the

following week. This approach to care disturbs continuity of care and timeous intervention once a need arises. There are no health information sessions offered to pregnant women, except for antenatal exercises that are done infrequently.

5.2.4 Informal Conversations with Pregnant Women at the Three Clinics

Issues of concern raised by women were lack of communication and supervision by midwives. They are not informed of many aspects of their health care.HIV counseling is done in a group format. The women's bloods are also obtained in a group of four at a time and women were concerned about the possibility of misidentification of bloods which might lead to incorrect diagnoses.

Women had a lot to share with the researcher about psychosocial stressors which they experienced, probably because they waited hours before being attended to. Examples include:

A31 year-old para 3 gravida 4 woman. Her husband was shot dead in 2006. She has a boyfriend, a married man who is committed to his wife. The woman carried an unplanned pregnancy. She is surviving on wages earned as a casual housekeeper, working twice per week, earning R640 per month. The above scenario highlights potential psychosocial problems including a lack of support, an unplanned and possibly unwanted pregnancy and inadequate finances to care for the baby.

Another woman was a refugee or an emigrant from another African country with three children. She came to South Africa in 1991but does not have an identity document. The children's births are not registered with the Department of Home Affairs as she does not have South African citizenship or residence permit, and as such she cannot apply for social grants for the children. She seemingly explained her situation to the staff, but did not get any assistance.

A 20 year-old retail shop casual employee studying journalism part-time was carrying an unplanned pregnancy at 30 weeks, fathered by a 21 year-old unemployed man. Her initial plan was to terminate the pregnancy, but she could not go through with it. She indicated that she is not ready for parenthood but is trying to cope with this demand. The boyfriend and her family are supportive.

In one clinic sitting of 13 women, an informal conversation led to women asking about pregnancy issues regarding painful coitus, ruptured membranes and breastfeeding**.**

Sporadic questions asked were for example “why is my baby kicking so frequently? Is it ok?” Women showed interest in the informal sessions as they probably allayed anxiety and clarified myths about pregnancy. The women in this group generally displayed a need for health information during antenatal care.

5.2.5 Interaction between Midwives and Women

The midwife-woman interaction was generally limited in all clinics and was basically directed by what had become the routine antenatal care process.

In one instance a midwife noticed a woman writing on her antenatal card and screamed at her without asking why or what she was writing. The midwife yelled “*you are not supposed to write in this card. If you are clever enough you might as well monitor yourself”.* The woman cried hysterically and within a few minutes started vomiting. The midwife ignored her as she claimed the woman was being manipulative. The researcher investigated the matter and established that the woman’s previous visit date had not been recorded by the midwife and she had filled in the date.

5.2.6 Conclusion

The above discussion confirms the existence of psychosocial problems which might impact upon a woman’s wellbeing during pregnancy which could be identified by the midwife and indicate the need for psychosocial support. The absence of information sessions at clinics represents a missed opportunity for information, especially in view of the fact that psychosocial assessment is not done as part of routine care

5.3 FOCUS GROUP DISCUSSIONS WITH MIDWIVES

Focus group discussions were held with midwives working at the three purposively selected antenatal clinics in Gauteng Province. Three focus group interviews were conducted, one group from each clinic.

5.3.1 The Interview Process

The midwives were informed about the interviews and given a period of three months to make a decision regarding voluntary participation. A consent form for participation was attached to the information letter and signed pre participation (AppendixM). As an inclusion criterion, participants were required to have provided care to pregnant women for a minimum of two years. This was in order to be able to share information about psychosocial risk assessment

and psychosocial support during antenatal care. Each group of midwives was interviewed at their respective workplace.

The clinic managers arranged a private room and coordinated the setting. Three focus group interviews were conducted. Two groups of five and one group of six midwives were interviewed. All participants were females. The researcher conducted each focus group and served as an observer, listener, moderator and analyser using an inductive process.

An interview guide with open-ended questions was used (Appendix P) for the interview guide.The interview guide was drawn up from the preliminary results of the self-administered questionnaires for pregnant women and the findings of the focus group discussions with pregnant women. The interview guide was used to direct and to stimulate the discussion.The average duration of the interviews was 55 minutes. Refreshments were served by the researcher at the end of each interview.

5.3.2 **Presentation and Discussion of Findings**

Within-group and across group data saturation was reached. These are the findings of the tape recorded discussions of midwives' understanding and experience of psychosocial assessment and psychosocial care during pregnancy.

The focus group provided a more valuable environment than individual interviews as participants positively influenced one another. The fact that the midwives were a working group and knew each other allowed them to relate to each others' comments, and they were able to challenge one another. This promoted self disclosure and open discussion. In their responses, midwives tended to narrate their experiences of psychosocial care rather than directly responding to the questions.

Typically they defined a situation which presented a particular psychosocial problem, then described the action taken by a midwife and the outcome of the interaction. This approach provided the researcher with an overall view of the participants' perceptions of psychosocial care. The stories were analysed by viewing their relevance to a psychosocial problem and the resulting intervention.

5.3.2.1 **The Midwives' Understanding of Psychosocial Care**

Regarding the participants' understanding of this procedure of psychosocial assessment, Table 5.1 reflects their various responses. The concept psychosocial, seemed to be familiar to the participants. Participants did not describe their understanding of psychosocial assessment but rather indicated what should be psychosocially assessed during antenatal care.

The three major themes that were developed from the participants' responses are social factors, psychological factors andassessment. Reflected within the social and psychological themes are factors that relate to psychosocial assessment, which also provide a holistic approach to assessment during pregnancy.

Regarding stigma as a social factor, women were reported to have a tendency to move from one antenatal clinic to another with the hope that no one would find out about their HIV status; however, midwives are able to identify the status from the women's antenatal care card. Psychological factors included the emotional, mental status and sexual abuse.

Statements classified under the theme assessment, offer an explanation of the concept psychosocial assessment. A comprehensive assessment, which includes the physical, the social and psychological aspects is reflected within the participants' responsesreflecting in Table 5.1. Furthermore, the women's employment status and their emotions and feelings also reflected in the midwives' responses.

Table 5.1: The Midwives Understanding of Psychosocial Risk Assessment

Major Themes	Sub-Themes	Descriptions
Social Factors	**Social problems**	"Social benefit and the risk to the mother and baby" "Having problems inside and outside the house" "Anything that is affecting her socially as a human being"
	Stigma/Discrimination associated with an HIV positive status	"The stigma associated with HIV / AIDS (stigma, discrimination) "To avoid stigma, they run away from the environment where they stay as they are going to be identified if they take dual therapy or milk for the baby" "They think we won't understand the things that were written"
	Economic	"Some lack accommodation and employment"
	Environmental	"Social is the environment or socialization, cultural values" "Social background, home situation, financial support" "The background that the woman comes from"
	Life events	"A woman whose husband died in a car accident while she was pregnant" "Divorced woman" "Woman in mourning, but still wants the baby even if the husband is dead"
	Cultural beliefs	"An influence by others" "What is expected from her by society" "What to do and what not to do when you are pregnant"
	Unplanned pregnancy	"Women not ready as some ask about abortion"
Psychological Factors	**Sexual abuse**	"Women pregnant due to incest or sexual harassment"
	Emotional	"How does the woman feel about the pregnancy" "Sometimes you get clients that are angry and are not happy about the pregnancy"
	Mental	"Psycho talks about mentality,psychological"
Assessment	**Employment status** **Feelings and emotions** **Comprehensive assessment**	"Assess age, working or not, the inside of the house" "We are normally happy that the woman is pregnant but we do not ask about how she feels" "I think it's a lot, the environment, the type of family, social community and cultural things that affect her psychology" "We should assess them in totality, viewing their mental state, physical state and social state they find themselves in" "Include the Maslow's Hierachy of needs in their assessment"

As stated by Shamim ul Moula (2009), psychological factors are the factors that modify one's behavior in response or behavior towards a specific stimulus. When these factors emerge from social contexts, they are referred to as psychosocial factors. The concept psychosocial, as defined by the Oxford English Dictionary (2008), is the impact of social factors on an individual's thoughts and behavior.

Shamim ul Moula (2009) further explains that this definition implies that psychosocial factors or social structural factors, in the context of health research, may affect an individual's health outcomes. According to the participants' responses, the social factors that influenced thoughts and behavior were existing social problems, social stigma in relation to an HIV positive status, environmental hazards, unplanned or unwanted pregnancy, life events, cultural and economic issues. The responses to these social factors were manifested psychologically through emotions for example anger, anxiety, fear or dismay.

What seemed to be a challenge to participants was the lack of a clinical guideline that would guide them in conducting a psychosocial assessment. Consequently, psychosocial interaction occurred mainly through intuition, often in a subtle way. For example, if the midwife establishes intra-uterine growth retention when doing abdominal palpation, she might probe further and discover the lack of an adequate or balanced diet, or a history of alcohol consumption, all of which might have a negative impact on foetal growth and development.

The bio-psycho-social approach to antenatal care

The bio-psycho-social approach could be adopted in an attempt to offer comprehensive and holistic antenatal care.The objective of a bio-psycho-social approach to antenatal care is to organize antenatal care within the context of midwifery care as reflected in Figure 5.1.

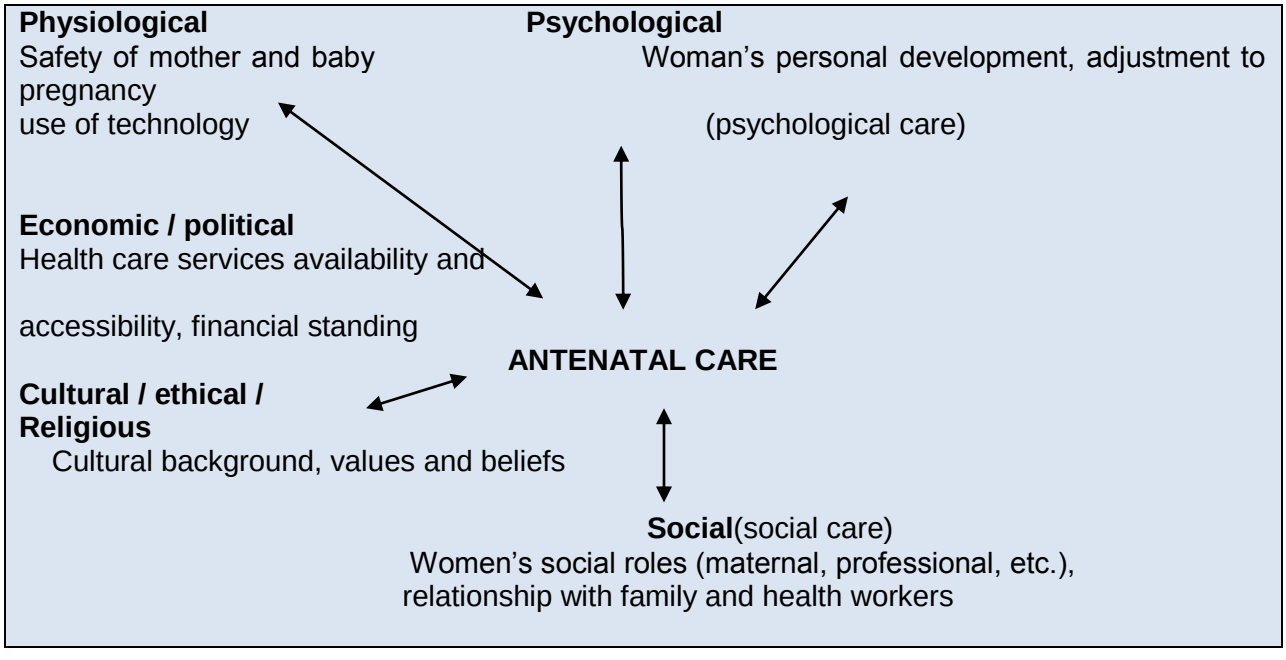

Figure5.1: The Bio-Psychosocial Perspectives of Antenatal Care

The bio-psycho-social approach as applied to this study forms the basis of a holistic antenatal care approach as it includes the physiological, psychological, economic, political, social, cultural, ethical and religious determinants of health.

5.3.2.2 **The psychosocial risks encountered by midwives**

The common psychosocial problems that the midwives encountered were HIV/AIDS; unemployment; lack of accommodation; no family support system; smoking and alcohol consumption; teenage pregnancy and poverty. All participants in all 3 focus group discussions agreed to the importance of the midwife assessing women psychosocially.

Their reasons were based on the perceived need for basic support for the woman and for referral to specialized services if a need arises.

The common psychosocial resources used were social workers, psychologists, services for termination of pregnancy, adoption agencies if the pregnancy was unwanted, and referral for anti-retroviral therapy (ART) for those who were HIV positive with a low CD4 count.

Table 5.2 presents psychosocial problems that midwives commonly identified, although the problems were not elicited through formal assessment but through intuition.

Table 5.2: Psychosocial Problems and Midwives' Interventions

Identified Problem	**Psychosocial Support Offered**
A woman with malnutrition	*"I advised her on correct diet and referred her to feeding* schemes"
Woman without a place to stay	*"I arranged for a place to stay through the social worker"*
A 33 year old, unplanned pregnancy, single and on ARV's	"*Counseled and referred to a psychologist*"
A home delivery, baby not accepted by family, mother wanted to leave baby in the labour ward	"*I counseled and contacted family overnight, family accepted baby and sister sent to fetch mother and baby"*
Opted for termination at a very late gestation	"*After sonar was done,the mother saw the foetal heart and decided to keep the baby"*
Woman opted for termination as unemployed	*"Family was contacted and agreed to support and discouraged her from opting for termination"*
Women without baby clothes	*"We normally donate some clothing and anything we have"*
Women refusing to test for HIV	*"Counsel them again, listen to their problems and show them that there is another side of the picture*"
A woman who had a disabled younger sister under her care, both unemployed, supported by partner	*"Advised to apply for social grant and referred to social services"*
Attitude conflict between midwife and woman	*"Referred for second opinion to other team member to handle"*
Woman refusing to accept assistance offered due to fear of intimidation	*"Be open as a midwife and not close them out"*

5.3.2.3 Psychosocial care offered by midwives

The actions that the midwives took prior to referral once a psychosocial risk was identified, were: listening to the woman attentively, giving women options like termination of pregnancy or adoption, encouraging family involvement and advising women on applying for social support grants. Listening to the woman is the appropriate first step in offering support. As stated by Lavender et al (1998) and Hildingsson and Hággström (1999), psychosocial support can be viewed as a process of allowing the woman to express her problems.

The midwife can provide listening and empathy by offering the woman an opportunity to talk. Through a midwife's attentive listening, women can be motivated to open up and seek more help. Women were reported by one focus group to have often returned after they had been given support, to give feedback and to thank the midwives. Health information sessions also assist with eliciting psychosocial problems. The midwife also uses observation to identify possible psychosocial risks. For example, if the woman looks shabby and unkempt one needs to probe further into the possible cause for the woman's poor hygiene and appearance.

Raisler and Kennedy (2004) concluded their literature review on midwifery care of poor and vulnerable women in the United States by stating that the midwife's ability to listen, and belief in the woman's inner strength and ability, will empower women and allow them to contribute significantly to the management of their pregnancy.

The psychosocial support that midwives offered once a psychosocial problem was identified seemed appropriate, as reflected in Table 5.2. The results of a randomized trial entitled "Can Midwives Reduce Postpartum Psychological Morbidity" by Lavender et al (1998) revealed that the most useful psychosocial care involved listening, emotional support, counseling, understanding and explanation, all of which seemed to have been applied by midwives in this study.

5.3.2.4 The importance of psychosocial care

The findings from the focus group discussions indicated that psychosocial assessment and care was important during pregnancy. The respondents further highlighted the importance of an appropriate guideline and a record for psychosocial assessment and care as reflected within the following responses:

Respondent 1*: "If you look now the state of affairs of our antenatal card it just says social…smaaall… (**emphasizing**), and you can ask anything... there is nowhere psychosocial issues are recorded"**Respondent 2:** "Yes,something like TICK,TICK,TICK, will help maybe something like TICK,TICK,TICK, will help checklist, tick, tick just ask relevant questions,with a checklist I think we would be made aware of the things that we normally don't ask."*
The above response is in keeping with Olsson, Sandman and Jansson (1996) that topics not appearing in the printed antenatal record were seldom discussed.

Researcher: "*Is it the woman or the midwife who will tick the checklist?"*
Respondent 2: "*The midwife will fill the checklist"*

*"Yes, (**All participants)** the checklist will remind us to go deeper, you know beyond the surface, to go deeper than the care that we normally give because it's useless to pretend as if everything is fine whereas the patient has a big problem that can lead to complications, but once we have something that will guide you to ask something, even if you don't ask all the questions, but you know maybe you can highlight, and maybe you pick up something, that will be very helpful"*
Respondent 4*: "There must be a tool because on the green card is just a small line, where we ask for example, it is not written clear, just says "social"... therefore if there was a guideline regarding what should be done it will be appropriate for the pregnant women"*

All participants in the focus groups agreed that psychosocial assessment and psychosocial support should be included within routine antenatal care. One participant asked: "*Who will conduct the psychosocial assessment?* Her concern was that one needs to give full attention to each woman and not to rush the queue. Following a short discussion amongst participants, they agreed that the midwife has the ability to assess the woman psychosocially although she might not have time to do so.

They maintained that basic psychosocial support is often offered by midwives at the clinic as the resources for referral are mostly inadequate or not accessible.

Most literaturedescribed the purpose of social support as being to make woman feel respected and valued. The quality of support is more valued than the quantity. Research has revealed a growing body of knowledge regarding the influence of psychosocial factors on the outcome of pregnancy.

5.3.2.5 **Challenges faced by midwives**

The following challenges were reported by participants as obstacles to the implementation of psychosocial assessment and psychosocial care:

- The service organogram is currently not clear regarding who should offer psychosocial care and how;
- The shortage of staff;
- Work overload resulting from an average midwife: woman ratio of 3:70;
- The increased number of pregnant women, especially teenagers, who need special attention;
- Language differences due to the high number of foreigners accessing the services;
- Midwives have administrative responsibilities;
- Inadequate physical structures, specifically consulting rooms, to offer privacy or to accommodate the women's partners;
- Women normally do not open up, probably fearing discrimination by midwives and victimization by the partner;
- Some midwives' negative attitude towards the woman. This issue was raised in 2 of the 3 focus groups ;
- Psychosocial assessment might be time-consuming as there are a lot of psychosocial problems that the midwives are currently encountering;
- Overpopulation of antenatal clinics by refugees, leading to work overload;
- Communication breakdown due to foreign languages which need interpretation and often lead to poor antenatal history- taking;
- The women with speech and hearing disabilities and women who communicate through sign language in which the midwives are not competent;
- Women who are illiterate, who cannot benefit from the health information displayed on posters and charts;
- Large numbers of HIV positive women who are attended to with inadequate resources;
- No formalized guidelines for psychosocial assessment; each midwife records what she feels is appropriate;
- Much as the antenatal card provided an important working tool for midwives, there is no standard tool available to record the information as the antenatal card is non-specific, and the focus is mostly on medical conditions and problems.
- The social service that is mostly inactive. In one clinic a non-government organization offers its services as the social services allocated for that clinic are failing.

According to the International Council of Nurses (2009), the heavy workload for nurses continues to be a key challenge. A global survey conducted, with South Africa participating, revealed that 46% of nurses indicated that their workload is worse today compared to five years ago. This heavier workload may have a negative impact on the quality of care that patients receive. Menon et al (2010)concluded that the crowding and pressure of work experienced by midwives may cause stress, which may lead to them being less sensitive to the psychosocial needs of women.

The World Health Organization, following its study in Thailand, Argentina, Cuba and SaudiArabia (Baldo, 2001),recommended a reduction of theeight antenatal visits to four visits for low risk women, using the WHO antenatal risk classifying form, but with some emphasis on psychosocial assessment and psychosocial care. Although some women from the WHO trial were reported to have been dissatisfied with the reduced visits, the reduced visits lowered costs for midwives and mothers, reduced waiting periods that are often a concern for women (Villar, Bergsjo, Carroli, Gulmezoglul, 2003), and werenot associated with an increase in adverse outcomes of pregnancy.

The current number of antenatal visits for Gauteng Province, as indicated within the Gauteng Department of Health Antenatal Care Policy Document (1999), is actually eight visits for low risk pregnancy (which is double the number of recommended visits by the World Health Organisation). Despite the eight antenatal visits offered, psychosocial care is not addressed.

A study by Umeora, Sunday-Adeoye and Ugwu (2008) in implementing the new WHO antenatal care model in Nigeria, concluded that only 25% of women were classified as high risk. The other 75% were low risk and could safely be allocated to the modified antenatal care program. These statistics tally with the findings of WHOduring its own study. In the researcher's opinion, the reduced number of antenatal visits can probably be applied within the South African context, as most women with low risk pregnancy attend antenatal care at level 1 clinics and Maternal Obstetric Units (MOU's) as reflected in chapter one, subsection 1.2.8.2,p14. However, a limitation of the WHO classification or assessment form is that it addresses physiological risk screening only, and should be augmented by a psychosocial risk screening tool in order to holistically classify the woman as low or high risk.

Menon et al (2010) further stated that it is important for health professionals to ask pregnant women about their feelings related to the current pregnancy, childbirth and future

motherhood,and to give the woman who expressed fears an opportunity to discuss them, paying special attention to primiparas and to multiparas with previous negative experiences of pregnancy and labour.

In a free maternity service context (as in South Africa's public health care system) where the number of pregnant women attending antenatal care is overwhelming, and with limited human resources, it is unlikely that women will receive individualized, adequate and valuable psychosocial, emotional and holistic care from the midwives.

5.3.2.6 **Recommendations by the focus group participants**

- Midwives need to be empowered with interpersonal and communication skills and have access to a sign language interpreter;
- The establishment of antenatal campaigns such as "pregnancy awareness" and "breastfeeding" weeks that will involve partners so that they can support the women; the midwives offered to come in and facilitate such campaigns over weekends.
- The establishment of a "pregnant women's men's club", to involve the partners and minimize the existing psychosocial problems that are partner-related. Prospective fathers form an important part of the social network and the father groups might promote the man's identity as a father.
- Midwives request debriefing sessions as they are overwhelmed by their duties as reflected in this response: "*we also as health workers we need to debrief, because listening to those stories, you know, you take those stories home, what I observed, when a nurse has left a patient with a problem, the first thing when she comes in she will be asking about that patient. So nurses also need debriefing to relieve themselves because we take the patient's problems and make them yours, so you will end up not being effective at the end of the day if you are getting many problems you know, without that debriefing sessions".*

The importance of guidelines was reflected in the following response: **Long pause! Respondent 3:** "*What comes to my mind as a recommendation is let's have the guidelines on psychosocial care…even if it cannot be implemented now, is for the future, let it be incorporated into antenatal care, even if it can be small it will make a difference, you know to say what type of questions to ask"*

- The importance for doula support for women during pregnancy.

A “doula” is a Greek word for a “supportive companion” for a woman in labour. The role of the doula is to support a woman physically, emotionally and psychologically and address women’s informational needs. Doulas are trained and experienced childbirth supporters who attends to women through the entire birthing process (White, Duncan and Baumle, 2005).Within the South African context, for example, a doula is trained through a six month part time course offered by the Women Offering Mothers Birth Support Organization (WOMBS) (van der Westhuizen, 2011).

van der Westhuizen, (2011) further described a study by Kaibe (2008), in South Africa to explore the importance of a doula during labour, led to the finding that the presence of a doula reduces the workload of a midwife, giving midwives an opportunity to give some time to offer psychosocial support to the laboring women. In addition to being an additional form of psychosocial support, the benefits of a doula, according to several research studiesfor example Klaus, Kennell and Klaus,(1993) as stated by Kabie (2008), is a reduction in the duration of labour and assisted deliveries.

5.3.2.7 **Conclusion**

The focus group findings are similar to the results of the midwives cross-sectional survey that were discussed in Chapter 4.The findings provide viewpoints of almost 250 midwives employed in a range of provinces and different maternal services in South Africa. From the results and findings it is apparent that:

- Psychosocial risks exist during pregnancy, with HIV/AIDS contributing significantly.
- Midwives encounter psychosocial risks on a daily basis.
- There is a need to assess and support the women psychosocially during pregnancy.
- Midwives felt they are not adequately equipped to assess and support the women psychosocially during pregnancy.
- There are no guidelines in place and no tool exists to assess the psychosocial health of women.

5.4 **FOCUS GROUP DISCUSSIONS WITH PREGNANT WOMEN**

5.4.1 **Introduction**

Focus group interviews were conducted with pregnant women attending antenatal care at the three clinics. The researcher wanted to establish the women’s subjective experiences of psychosocial care during their antenatal visits. Pregnant women waiting for their routine antenatal check up were conveniently selected to be part of the focus group discussion.

Focus group discussions occurred after the women completed their routine antenatal check up. Assurance regarding anonymity was communicated to participants throughout. The researcher made herself available to offer psychosocial support where necessary by listening to women's concerns and resolving issues within her scope like offering options for unwanted pregnancy and referral to social services through the sister in charge of the antenatal clinic.

Only women who had three or more antenatal attendance at the selected clinics were regarded as being able to share information about psychosocial problems and psychosocial support during pregnancy. Potential participants were recruited while they waited in the clinic's waiting room. The women's antenatal record cards were reviewed to verify that they had three or more previous antenatal visits. Willing participants were requested to sign a consent form prior to the interview (Appendix O), after being informed about the study and its purpose. They were also reminded that participation was voluntary and that they were entitled to withdraw even during the interview session.

5.4.2 **The Process of the Interviews**

Discussions took place in a private room provided by the clinic manager. A semi-structured interview guide was used for the interviews (Appendix N). The interview guide was piloted with a group of pregnant women in one of the clinics and appropriate adjustment was made. Women were encouraged to express themselves in their preferred language. The common languages used by participants were Sesotho, IsiZulu, Xhosa and Tsonga. The researcher and assistant researcher are competent in these languages. Discussions were tape recorded after informed consent from participants had been obtained.

Participation of pregnant women in a focus group discussion offered the women an opportunity to express common feelings. Participants shared similar characteristics in that they were within the childbearing age, of similar social class and did not know one another outside of the antenatal clinic. These factors encouraged a more honest and spontaneous expression of their views. Participants were reflexive, thoughtful, articulate and willing to engage in a discussion about their experiences of childbirth and appeared to be comfortable with one another, and as such engaged in a lively discussion. Each discussion lasted approximately an hour.

The less-inhibited participants tended to encourage engagement of shy participants. Subtle group control was used by the researcher for dominant, rambling and shy participants. According to Kitzinger (2000), focus group interviews are appropriate for groups who seem to

be disempowered and who might feel reluctant to give negative feedback. This was applicable to pregnant women as they are mostly faced with routine care that is not usually questioned. Small tokens of appreciation were given to participants at the end of the interview.

5.4.3 Findings

Some of the women's responses are presented in the woman's language for the purpose of a better understanding of the viewpoint and further explained in English and boldened.

5.4.3.1 The extent of care and support offered

The women's response to the question on the care and support they received from midwives during their clinic visits indicated that basic antenatal care services were offered. The services included routine tests such as urine analysis, blood tests, weight measurement and abdominal palpation. Four major themes were generated viz. physical care, general support, psychosocial care and health information.

5.4.3.2 Major themes regarding care offered

Physical care

The physical care that women received during antenatal visits included abdominal examination, monitoring of foetal wellbeing, weight monitoring, blood testing, urinalysis and blood pressure monitoring. This care is routine, as conventionally offered to pregnant women. Physical health care seemed to be the dominant form of care received by women with, the focus on examination and assessment by the midwife. In one group, four of nine women (44%), indicated that the care they received was good.

G4H1 "*nna ka first time ba bile ba ntlhokomela, ba mpha card ya appointment gore ke tle neng, ba ncheka dimpa, bodi high blood, bodi HIV le moroto"* ***(First time around they (midwives) took proper care of me, giving me the appointment card indicating my return dates, checking various aspects such as my stomach, high blood pressure (BP), HIV status and urine.)***

G4H2 "*ngoba bayenza everything, baya ku cheka something, so maba thola ngine problem, bangi treater kahle" (****Because they do everything for me, doing check-ups, so that when they detect a problem they attend to it, treating me right.)***

G4H8 "*yebo ngingasho ukuthi nami ngizitholile, ngingasho ukuthi mangiza lapha ngo first day nga thola omunye usisi wa ngi tshela ukuthi kwenziwani lapha, mangi fika lapha bangi cheka i BP, nomchamo, after besi cheka bangi taper"* ***(Yes, I can also confirm that I got the necessary treatment. When I came here on the first day I found a lady (midwife) who explained the procedural aspects. They checked my BP plus urine, and also did some tape measurements.)***

G3E2 *"usizo lokuqala abasinikeza lona la ba fika basikhumule, basi cheke i BP, basigibelise naseskalini, basi cheke i weight ukuthi ngabe iweight yethu ingakanani, ba khona ukusnikeza amapilisi awe iron, ukuthi umtwana a khone ukuqonda kakuhle, ba sinikeza ayi two, amanye amavitamin, singa wa bhataleli"* ***(They help us first by undressing us, checking the BP level, and putting us on the scale for proper weight checks. They also provide us with iron tablets and vitamin tablets to assist in the development of the baby, free of charge.)***

G3E4 "*ba sicheka i BP"* ***(They check our BP.)***

G2A1"*nna nka bolela ntho e one fela gore like ke bone gore ke care e ba re refileng yona ke gore guider like gore re tsee madi for ntho e like if possible o positive so that go tlo protectiwa ngwana ke yona ntho eo fela e nkareng ke care e barefileng yona"* ***(One thing I can point out is that the care they provide is mainly in the form of guidance, encouraging us to do blood tests so that in case one is HIV positive proper interventions can be initiated for the protection and well-being of the unborn baby.)***

According to the National Health System (Vision, 2000) and the Constitutional Bill of Rights (1996), access to health care is considered a basic human right.

Psychological care

The only psychosocial subtheme that emerged was counseling. Women were familiar with counseling as it is routinely done as part of voluntary counseling and testing (VCT) for HIV. **G4H3**"*care engiyi tholayo is good for me, especially i counseling and I understand i counseling"* ***(The care I get is good for me, especially the counseling part, as I now understand the counseling process).***

General support

In one focus group, women appreciated the fact that midwives advised them to come directly to the antenatal clinic and not to queue when they do not feel well.

G3E3*"maugula or ufeela something ongayi understandi, uze straight la kithi kule kliniki, ungasa qali ukufola, uthi ufuna ukubona udoctor, uze straight kithina siku cheke"* ***(The midwives advised us that if one is sick or feels strange she should come directly to them at the clinic for examination, without having to wait in the queue for a doctor).***

Health information

In one of the clinics, women seemed satisfied with the health information classes that were given sporadically as group sessions. The health information covered aspects such as minor disorders of pregnancy, diet and how to take care of the newborn. This was evident in some of their responses such as,

G3E1 *"masiqala baya sifundisa abosister ngoba siyaqala ukuba pregnant, baya kufundisa ukuthi uba nama disease anjani, amadisease abangwa yini. Ma u pregnant umele ube njani, ungadla ini ezoyenza ukuthi igazi lakho libe phantsi"* ***(In the initial stages the sisters (midwives) teach us, guiding us, this being our first pregnancy. Advising us on the types of illnesses we can expect and the cause thereof. They tell us how to conduct ourselves during pregnancy, and guide on the types of food recommended to help maintain adequate blood levels).***

G3E2*"mina ngingathanda uku add kula usisi akushilo, ukuthi usizo esilutholayo masiza la ekliniki uma singabomama aba pregnant kuningi abasifundisa khona. Ba fika ba si tjela ukuthi masi pregnant, mhlawumbi singaba ne zifo ezithile uthole ukuthi thina asazi. Baya sikhuthaza ukuthi kumele senze i HIV test, and basicheka nokuthi kumele ukuthi sidle kanjani, sidle ukudla okunjani. Uma banga thola ukuthi si HIV positive, basi tjela kuthi mele sidle ukudla okunjani, mele sizi phathe kanjani. And futhi enye into e basi siza ngayo ukuthi basitjela ukuthi uma sesi mtholile umtwana kumele umnakekele kanjani, ngayiphi indlela"* ***(In addition to what the other lady has said, I can confirm that the assistance we pregnant women get when we visit the clinic is valuable, and the midwives teach us a lot. They inform us that during pregnancy we may develop diseases we are unfamiliar with, and therefore encourage us to do regular tests, including HIV test, eat properly and recommended food categories. When they discover that we are HIV positive they advise us on the appropriate dietary***

measures, how to conduct ourselves and how to effectively care for the baby upon birth).

G3E2 *"nge sinye isikhathi bese ba hlala nathi phantsi basi tjela ngendaba ya pregnancy"* ***(At times they sit with us and discuss pregnancy aspects.)***

5.4.3.3 **Is the psychosocial care offered to women adequate?**

When asked whether the care and support they received was adequate, responses were as follows:

G3E1 ***"ya, siyakuthola ngoba mase ungena oyi ione siqala basicheka iBP siyaqala, then kuba khona isikhathi sokuthi siyafunda, after that kukhona isikhathi sokuthi siya embhedeni, baya kucheka, then lapho uya khona uku xoxa ukuthi yazi sister ngine nkinga e so, so, so, then yena ukubhekela imedication ongayithola for lento ekuphethe" (Yes, we do get care and support, because in the beginning they check BP levels, teach us, and do check-ups on us whilst we are lying in bed. During the check-up sessions we get the opportunity to discuss our health problems with them, and they provide medication suitable for our respective ailments).***

G3E4"*kusho ukuthi kwesinye isikhathi awuyitholi isupport ngale ku sister, mauthi mhlawumbe kukhona ukuxoxa, ukuthi ku khona anga kuncedisa ngakho mhlawumbe umxoxele ukuthi mhlawumbe une nkinga ekhaya akusize ngayo, or ukuthi kube khona ithuba mhlawumbe kuthi nje, kuse celeni, mhlawumbe sesi yi two sikhulume, mhlawumbe sixoxe ngimtjele ukuthi kune nkinga ekhaya kuphi*…(Researcher) ***oke wa zama ukukhuluma no sister?*** *Eehh nje ngoba ngangi nenkinga ekhaya nga tjela u sister*…(Res) ***Wena wayenza njani nga lo nkinga, wamtjela u sister? ….*** *Mara wa lalela nje wanga phenduli*…(Res) ***Wangaphenduli?...****eeeh****…* (Res)***And then wa yenza njani ngalo problem?…****Ngahamba, angithi manje be anga ngi naki"* ***(Sometimes you do not get the desired support from the sister (midwife). For instance, you tell her about the problems you encounter at home and she just ignores you, never responding, and you leave)***

G3E5 *"nami ndizocela ukugcwalisa kancane, kose kushiwo. Kokunye usufuna ukwazi kabanzi, mhlawumbe ngesimo okuso uma upregnant, uthole ukuthi mhlawumbe unurse use uvele wa theta wa kwata, bese uyasaba nawe ukuthi uphinde ukhulume umcele ukuthi manje ndifuna ukwazi ukuthi makuso kuqhubekani, ngoba umbona ukuthi usesimeni esingajabulile, uthole*

ukuthi ukwatile, use uyathetha. Manje kanjalo awukhoni ukuthi bese uhlala naye phansi uya mbuza ke. Khona siyafisa, kuningi esifuna ukukwazi" ***(I also like to add to what has been said. Sometimes you want to know more about the pregnancy condition and related aspects, only to find that the nurse (midwife) is already upset and moody, and not in an approachable state. Then you become discouraged, though there is so much we want to learn).***

G3E6"*ngiya neliseka ngo kunye**,** njengoba base beshilo, mauthola abo sister ba right, uba right nawe, uya khululeka"* ***(I am satisfied with some other aspects. As previously stated, when you find the sisters (midwives) in a right, welcoming mood you also become right and loosen up).***

G3E2 **"***mina ngi ngasho ukuthi asineliseki kuko konke, ngoba kuno kunye ekumele ukuthi sikwazi masi pregnant. Uthole ukuthi mele kuthi sikubuze kubo, ngoba okunye baya sitjela kona.Uthole ukuthi se uya saba ukuthi ubuze ukuthi u mama onjena ke kusho ku chazani, ya bona. Ngoba abasinikezi lokhu ukukhululeka, leyo nkululeko yokuthi nawe unga buza ukuthi manje la kuhamba kanjani"* (**irritated voice**?) ***(I can say that we do not become wholly satisfied in all facets, as we want to learn more about pregnancy-related matters. However, sometimes we are afraid to ask what is the meaning of this or that. Although they do explain some aspects for us, nevertheless at times they do not make you comfortable to probe further).***

Handley (2006), in a study on emotional responses to pregnancy, recommended that the provision of accurate, consistent information to pregnant women in a timely manner will give women a basis on which to understand the events of their pregnancies. Furthermore, providing adequate information reduces uncertainty, anxiety and depression.

5.4.3.4 **Clients' expectations of care**

Although expectations were broadly defined by participants, the type of care that was offered to the women seemed not to be what they expected. The factors that contributed to the women's expectations not being met were generally that the care was impersonal and hurried, leading to lack of interaction or attention as evidenced by the following responses:

G2A1*"not at all….**not at all, ok?**...cause like sister sometimes gona le gore motho o mong abe pregnant and then atla mo kliniking o sheba gore like o expecta somebody gore a bolele*

le yena a mmotsise gore o feela jwang ka this pregnancy, and then o tlo kgona go manager naa, kehore like a tlo thola guidance kagore gona le a tlabeng a thoma go thola ngwana, like a thole that thing ya gore o tshwantse a dire jwang, a bereke jwang, maybe o tshwanetse a je eng a seke a ja eng? Wa nhlaloganya? Dilo tseo gase re dikereye for the first time gare tla mo kliniking, redi kereile maybe later on gona nou like kgao kgutla bababedi, ledi students…" ***(Not at all, because at times one attends the clinic hoping to have a discussion (with midwives) around pregnancy stuff, such as how you are feeling, are you managing, what to eat and so forth. Particularly when it is your first pregnancy. However, we are not provided with all the necessary information when coming here for the first time, only to learn more on our subsequent visits, particularly when student nurses are around).***

The women felt that the care received was not ideal as they were attending clinic at a public institution and it is free, whereas at a private clinic, care is individualized as women pay:

G4H1"*re expecta gore vele ke yona care e ga ngata nee, rona batho especially, especially kodi private hospitals le dikliniki, gare expect go thola care ekabeng re e thola ko private, oyabona, mo goreng private o ka khona go ikemela ore haee, akere…(**emphasizing)** ntho yako government ke gore eishh, batlo ojwetsa se , osekaba le thuso ke gore o tlo latela mo kellelong yahao psychologically o se oitukisitse kelellongya hao gore mole eba taba ya gore ke government, o ya bona, gase mo ke etsang? ke patalang teng oya bona, so se oipuditse kellellong ya hao hore ke tlo mamela ntho enngwe le enngwe, uyabona, is either e right or e wrong"* ***(We become accustomed and receptive to the kind of treatment or care meted out here at the government institution, whereas if it was at a private hospital or clinic you are able to be bold and assertive. But we psyche ourselves to accept anything they tell us at government institutions, whether right or wrong, as we are not paying what can we do anyway?)***

The women's desires were sometimes not honoured:

G4H1 "*wa bona, mo batlare hae, go normal, (**emphasizing**), oyabona noma asa sheba hore pain e eile deep hakakang mo go wena motlhomong wena ka mokgwa oe beang ka teng, oe bea hannyane, uyabona, maybe ena haaka e cheka aka thola something e wena motlhomong oka senkeng hore ke ntho e serious ha kalo, but then just for, ko private, ntho e nnyane wa ebua gore eish letheka laka le mo le eng le eng, le eng. But then rona gare tla mo re itjwetsa gore it's normal , everything is normal, ha kena le this back pain its normal gosho gore noma ke mo jwetsa, noma ke tshwanetse go mo jwetsa, but is like, it is normal".* ***(You see, here***

even if you are feeling some physical discomfort they (midwives) will say it is normal for a pregnant woman to feel that way, even if with some intensive examination they would have discovered more on you. So you end up not informing them of some ailments, such as back-pain, because it is "normal", whereas at a private institution they attend to even seemingly minor ailments).

Vanagienė, Žilaitienė and Vanagas (2009), in their study to establish the quality of health care services provided at Kaunas city health care institutions, concluded that antenatal care-related expectations of pregnant women as described in the literature fall into four categories: a wish to be provided with adequate information; emotional support; general support with the management of their pregnancies; and a wish to be provided with professional care.

Ledward (2000) made a comment in an article discussing justice in relation to changing childbirth that a discrepancy may exist between the expectations of women using maternity services and what the midwives can offer based on available resources. Nevertheless, both midwives and women need to negotiate and establish achievable priorities based on women's needs, bearing in mind that an expectation is an ideal that can sometimes not be realistically attained.

With regard to the findings of this study, women seemed to value antenatal care. Interventions, for example, scans and being referred to a doctor or hospital, played a role in reassuring a woman that the pregnancy was progressing fairly well. Two women from one group and one woman from another wished to be assessed by use of ultrasonography as reflected within the following response:

G4H5 "*What is not ok with me is not to have a scan at the clinic to check the baby, isonar"* .Ultrasonography seems to be popular amongst pregnant women. A descriptive cross-sectional study by Fawole et. al. (2008) at the University College Hospital, Ibadan, Nigeria, on clients' perception of the quality of antenatal care revealed that 55,4% reported that ultrasound service was lacking.

Women were also concerned about not being able to ask midwives questions, and there were comments about intimidation and the attitude of some of the midwives. The prevailing antenatal situation may lead to women experiencing pregnancy-specific anxiety. Anxiety is defined by Handley (2006) as a diffuse apprehension, vague in nature and associated with

feelings of uncertainty and helplessness. Anxiety may be generalized to the pregnancy or be specific to identified concerns like lack of information or the attitude of the midwives.

G3E4*"yonke into engiyi zelayo bangiyenzela, mara sometimes uphuma la ungakhululekanga …**uphuma wenzani?**... Ungakhululekile…**ungakhululeke, why?**...ngoba sometimes bayagubuza into, uthola ukuthi uyaqala ekliniki mabe buza ugcine nini ukuya esikhathini, uthole ukuthi awusakhumbuli, baya ku shouta, awukhoni noku cabanga or ubuyise ingqondo ukuthi ngagcina nini.Yaa, ukuthi abakhulumi nje nawe kahle ukuthi nawe ukhululeke, uba chazele…* ***(They attend to almost all my needs, but sometimes you leave the clinic uncomfortable, unhappy. This is because sometimes they ask you a question on your first clinic visit, such as when last did you experience your menstrual cycle. When you are unable to recall or you fumble a bit they shout at you, making the situation worse. It is better when they talk to you nicely, then you can explain a lot of things coherently, feeling at ease).***

5.4.3.5 **Satisfaction with basic antenatal care**

The responses from all the 4 groups regarding the general psychosocial care offered led to the generation of major themes acknowledging both satisfaction and dissatisfaction with the management of their pregnancies by midwives, as reflected in this response: *"The service is excellent, nurses are friendly and helpful. The only problem I have experienced is that even if you come late with 5 minutes they send you back home, irrespective of circumstances or even bother to ask you why you are late, to be late is better than not tocome at all.*

The themes established generally focused on the pregnant women's feelings about the care they received from midwives, the women's interaction with midwives and barriers to communication. The most frequent themes were harassment, communication, fear and the midwives attitude.

Table 5.3: Major Themes, Sub-Themes and Women's Responses

Major Themes	Sub-themes	Descriptions
Harassment	**Disrespectful**	*"They shout at you, you can't even think"* *"They don't ask or talk to us properly, they harass us"*
	Insulting	*"There is one sister who would say, you groups of fools, you are a fool, does it mean that one becomes a fool once pregnant?"* *"They call us names"*
	Pompous	*"They tell us that their pregnant daughters consult private doctors"*
	Swearing	*"She is vulgar, she must just stop being vulgar, maybe the situation will be better"*

Table 5.3 (continued)

Major Themes	Sub-themes	Descriptions
Ineffective communication	**Disregard**	*"She just listened, but did not respond"*
	Arrogance	*"If you happen not to hear what she was saying, she won't repeat herself"* *"They talk as if they informed you before, with you just arriving, not knowing anything" (**firm and angry**)*
	Language barrier	*"The thing is, we don't understand the languages, they don't repeat.* *"They only help those who talk Zulu or Sotho"* *"That woman did not understand Zulu and the nurse shouted at her as if we are enjoying what she was doing to her"*
Service standards	**Lack of consultation**	*"The nurse undress you and check you, let you lie and touch you but don't tell you what is happening, I want to know how things are"* *"Say you have a problem and they refer you to the doctor, you expect the doctor to tell you something after sonar, but he just say go, you are finished"* *"If you had a problem and come back for check up, they no longer tell you how things are"* *"They can't even tell us that we have an urgent meeting, something like that, they just leave us here as if we are nothing"*
	Punctuality	*"They start late to work, we arrive here at ten to six"* *"I waited here until 12 without being attended, they said it was punishment because I arrived at 7"* *"Sometimes if you ask, they respond only after two hours when your time is already wasted"* *"They sometimes go for tea or lunch and come back after a long time"*
	Mutual participation	*"Re bontshane, and ha kena le ntho ke e discusse le ena, ha kamogelo eseyo, ke tlo tshaba,* *so hake tshaba it means gagona tswelopele le ena aka se itse hore bothata baka ke eng?"**(Communication should be both ways. I should be able to raise issues and discuss with the midwife. Otherwise, if she is not welcoming in this regard or approachable, I will be crippled by fear. If I am afraid to talk there would not be any progress as she will not be adequately appraised of my problems)***
	Lack of proper assessment	*"A re ke di normal pains, ga ancheka, are ke tle next week"* ***(You are pregnant, its normal pain, go home, there is nothing we can do"(all participants adding to this response)*** *"I told them I had pain, I thought they will check me, but they said that's the way its supposed to be as the baby is stretching, I expected a check up but did not get it"* *"When we come here we are told its normal, everything its normal, if I have this back pain its normal"*

Table 5.3 (continued)

Major Themes	Sub-themes	Descriptions
Xenophobia	**Discrimination**	*"One sister said; they fall pregnant more than South Africans"* *"One day bathi amaforeigners ukuthi sizala kakhulu, iproblem ya xala lapho, akudiphathanga kahle"* ***(One day they (midwives) remarked that the main problem is that we foreigners generally conceive and give birth a lot. That did not go down well with me)*** *"There is one sister who said don't bring people from Zimbabwe here"*
Lack of time	**Impatience**	*"Gabana nako ya hao, ba go fella pelo"* ***(They don't have time to listen to you, they are impatient)*** *"When you go for injections, you can't even ask why the injection, she will also tell you that she does not have time"* *"Le he o ka ema until bo past 4, still o tla go botsa gore ga bana nako, ga bana nako ya go go tlhalosetsa"* ***(Even if you can wait for a while, until around past four o'clock in the afternoon, she (midwife) will still tell you that they do not have sufficient time to explain issues)*** *"If you ask, they say, what are you saying? You are wasting my time"*
	Irritable	*"Yes she says she is doing her work, she only have time to do her work?"*
Attitude	**Arrogance**	*"Its ok, but they can be cheeky sometimes, bayathetisana"* *"If they can change their attitude, so that you can feel free to talk to them* *"They must change their tone the way they talk to people"*
	Unapproachable	*"They instill fear in us, you become afraid to talk to her and ask"*
	Humiliation	*"She makes a joke of you in front of others"*
	Emotional trauma	*"It seems like they are forced to come to work, sometimes you want to cry, you end up crying because you are hurting and that thing affects the baby"*

Table 5.3 (continued)

Major Themes	Sub-themes	Descriptions
Health information	**Lack of understanding**	*"Kena le dichanges mo mmeleng waka tse ke sa di understand, athi akunaproblem* (**harshly**), *just like that, there is no problem*!"***(I experience some changes on my body which I do not understand. She (midwife) just said "that's no problem". Just like that, "that's no problem")*** *"Ga ke understand gore what's going on ka diinjections tse ba re tlhabang tse, gab a re tlhalosetse niks"* ***(I don't understand what's going on with injections that we receive as they do not explain to us)***
	Superficial information	*"Information esiyi dingayo asitholi"* ***(We don't receive the information that we need)*** *"When you ask , they don't explain to your satisfaction, they leave you hanging* *"They told me that the baby lies in breech, they did not explain what a breech is, just that the baby is not lying correctly"*
	Yearning	*"Khona siyafisa, there is a lot that we would like to know and you are left without a meaning of what is happening"*
Cleanliness	**Dirty environment**	*"The other thing, this place is not clean, especially toilets, I came two successive days, when I came the following day I found the very same mess from yesterday"* *"Ngapha bathi kungcolile futhi kuna namaphela"****(Some women indicated that this place is filthy, even roaming with cockroaches)***

The following discussionspertain to themes as reflected in Table 5.3.

<u>Harassment</u>

Harassment was displayed by midwives shouting at women for no reason. Women felt intimidated as some midwives swore at them and called them "fools".

The Human Rights Watch (2011), as part of their study into the experiences of woman seeking maternity care, reported that women are often physically and verbally abused and are turned away from clinics without being examined despite being in labour. The Guidelines for Maternity Care in South Africa (2007) urge health workers who care for pregnant women to demonstrate respect and genuine interest in their clients, and to avoid an arrogant, judgemental or rude attitude. This principle applies even in the context of a sub-optimal working environment, which was frequently applicable to this study context.

Fear

Midwives were often unapproachable and most women were afraid to talk to them. For example, a concern was raised regarding fear by a primigravida who had so much to ask but was just afraid to do so. During her discussion this woman expressed fear ten times. This fear obviously increased her anxiety levels which might lead to stress and health consequences for mother and foetus if exaggerated. Fear has been found to often result in anxiety and inhibit communication between women and midwives (Menon et al 2010). According to Handley (2006), anxiety is a diffuse apprehension, vague in nature and associated with feelings of uncertainty and helplessness, which may occur as the woman is uncertain of her expectations or facts about her pregnancy.

Communication

Respondents expected an interaction with the caregiver through verbal, non-verbal and written communication. A need to be well-informed and to understand the situation was expressed as follows:

"*The midwives don't even tell us that they have an urgent meeting, something like that, they just leave us here as if we are nothing"*

Language barriers interfered with the women's and the midwives interaction during antenatal care. Midwives displayed both limited listening and attention skills. There was a sense of arrogance from midwives as evidenced for example by refusal to repeat themselves if women missed what they were saying.

"If you happen not to hear what she was saying, she won't repeat herself".

Women also indicated that midwives were "cheeky" most of the time. One participant suggested how midwives should communicate with them, as reflected within the following response:

"*Why can't they say, take off your shoes, your jacket, put your handbag down and get on the scale?* This statement reflects an expectation or desire for courtesy and caring.

Discrimination

Discrimination was evident against foreign women; a concern expressed in all the discussion groups. Another aspect of discrimination, mentioned by two groups, was about social status. A comment by one participant, *"enye into thina asifani, abanye barich, abanye abanamali abanokuthi bona baya eprivate. Mabasitreate ngokufana"* ***(We are not of equal means. Some of us are wealthy, whilst some are poor and cannot afford opting for private clinics. However, we all deserve equal treatment, irrespective of means).***

According to the Human Rights Watch Report (2011), refugee women experience specific abuse such as active discrimination and delayed or denied care.

Non- involvement of women

There was evidence of limited interaction between midwives and pregnant women during antenatal care. Women's participation in the management of their pregnancies was limited as they passively listened to the attending midwife. The women were not offered an opportunity for mutual participation.

"*Say you have a problem and they refer you to the doctor, you expect the doctor to tell you something after sonar but he just say go, you are finished"*

Punctuality

"*They start late to work, we arrive here at ten to six"*

Most respondents raised a concern about the adherence of caregivers to the appointment time as antenatal visits are mostly prolonged, as stated in the following responses:

"I waited here until twelve without being attended to, they said it was punishment because I arrived at seven"

"Sometimes if you ask, they respond only after two hours when your time is already wasted"

This appears to interfere with personal commitments. In his comment on the uplifting of midwifery in Africa, Mhlanga (1996) concluded that one way in which to facilitate a positive relationship between the woman and the midwife is through negotiation of the most convenient time for each pregnant woman to attend antenatal clinic. The working hours for staff should be adjusted as much as possible to suit women's needs.

The Gauteng Antenatal Care Policy (1999) as a guideline states that"working hours should be convenient to pregnant women and the health care providers. Evening and weekend clinics are acceptable to the province and not only traditional weekdays. This approach allows flexibility and accommodates women who are employed or have problems in attending antenatal clinic during specific periods as set up by the institution".

Attitude

A concern about the midwife's attitude was also raised by both midwives and pregnant women during focus group interviews. Midwives often seemed not to show sensitivity when managing women. This is very interesting as it is reported by midwives themselves, although midwives also claim that women can sometimes be uncooperative and non-compliant. The high response regarding the negative attitude of pregnant women by midwives might be due to the high incidence of psychosocial problems experienced by women and not being resolved due to lack of psychosocial care by midwives.

The World Health Day's Safe Motherhood initiative (1998) reported poor quality of interaction of women with health care workers stating that "women perceive health care providers as rude, patronizing and insensitive…interaction with providers can be threatening and humiliating". Women often feel pressured to make choices that conflict with their own needs. The situation leads to women being reluctant to use health care services.This was also reported by Thompson (1999) in her discussion of safe motherhood and human rights.

There is evidence of poor quality of interaction between midwives and pregnant women within this study, based on how midwives respond to the women. Gross, Armstrong, Schellenberg, Kessy, Pfeiffer and Obrist(2011), in their exploratory study on antenatal care in practice, remarked in their results that the midwives' behavior demonstrated power and they exerted a hierarchical control over pregnant women. Midwives in this study demonstrated a similar attitude towards women in their care.

Inadequate information

Women emphasized the importance of information as a matter of dialogue rather than a one-way information transfer from midwives to them. "*re bontshane, and ha kena le ntho ke e discusse le ena, ha kamogelo eseyo, ke tlo tshaba, so hake tshaba it means gagona tswelopele le ena aka se itse hore bothata baka ke eng"* ***(Communication should be both ways. I should be able to raise issues and discuss with the midwife. Otherwise, if she is***

not welcoming in this regard or approachable, I will be crippled by fear. If I am afraid to talk there would not be any progress as she will not be adequately appraised of my problems).

Bad treatment

Women felt that they were not treated well as individuals with needs. The main concern was at the reception desk. The staff was harsh and as a consequence they felt unwelcome.

Assessment

Women appreciated physical assessment and care for example abdominal examination and sonar, but psychosocial carewas perceived as poor. Women generally expressed fear of not being properly assessed during labour, which was a deviant factor as the context of this study was the antenatal clinic and not labour ward. Fear was based on their previous experiences and the discussions they had as pregnant women. Women who reported being in labour were sometimes turned away without being assessed. As a result, it was not uncommon for women to deliver between home and the clinic.

"u sister wami wa tetela phantsi. Wa fika la e labour bathi kuye usekude. Wabuyela wajika futhi, bathi usase kude, wa gcina e tetela phantsi, e passegini."… ***(My sister gave birth on the floor. She initially came here to the labour ward and was told that she is still far from delivering. She was again turned away the second time around, and ended up delivering on the passage floor).***

"lenna ke tlatsa taba eo yahore ha motho atshwere kedipain a tla mo sepetlela bebare ngwana o sale hole ba o jikisa. Hao fitlha ntlong hape pain ke yeo eya starter, ha o khutlela hape baya o jikisa". ***(I also confirm that there is a habit here in the hospital of pregnant women being turned away though in pains, being told that they are not yet due for delivery, only for those labour pains to recur when the women reach home).***

"*Nga teta, nga tetela phantsi, ngoba bangishiye phantsi, umntwana washaya ngekhanda phantsi. Even now i abnormal le ngane. Ngaphinda ngaba pregnant ngazo booka futhi la, leyo ngane ngayi tetela endlini ngoba se ngi saba, ngoba ngiyitete kuse busuku ukuza la e kliniki ngoba besengizitshelile. Azange ibe right nayo longane, ya shona nayo. Namanje ngiyasaba ukuthi ngiphinde ngitetele la ngoba futhi abangi treati right"****(I gave birth on the floor on my own because they neglected me, and the baby's head hit the floor. Even now the baby is*

abnormal. I fell pregnant again and though I booked at this clinic, I nevertheless opted to deliver that baby at home eventually due to fear induced by my previous experiences. However, that baby, born at home during the night, passed away. I am still afraid of delivering here at the clinic again due to the past ill-treatment).

Another factor regarding assessment was an indication that all ailments reported by women were regarded as normal for pregnancy by midwives, with limited attention given to the woman's concerns.

"*but then rona gare tla mo re itjwetsa gore its normal , everything is normal, ha kena le this back pain its normal gosho gore noma ke mo jwetsa, noma ke tshwanetse go mo jwetsa, but is like, is normal"* ***(But for us here we are psyched to treat everything as normal. Even when I have this back-pain I regard it as normal, and end up not informing the midwife even though I should do so in normal circumstances).***

Women further suggested that research in the labour ward should be conducted and someone should be appointed in the labour ward to oversee how midwives treat them during delivery: "*Okare re ka thola motho yo a katlo checkang dinurse tse hare tlo pepa, rena re a tshaba"* ***(It would seem better if there was someone assigned to supervise or check these nurses when we give birth, as we are now afraid of them).***

A group of women planned not to deliver their babies at the clinic.
"rona rele five, 1,2,3,4,5, re decidile gore gare tholele bana mo, it's either nna ke mmelegela kamo ntlong or keya ko sepetlela, ke ntho eleng gore rona re e decidile , akere ra tshaba, ne re shera rona…" ***(All five of us, we have decided not to deliver at this clinic. It is either one gives birth at home or goes to the hospital instead. We have resolved to do so out of fear).***

<u>Cleanliness</u>
The following are two responses from participants regarding the cleanliness of the clinics:
"One other thing, this place is not clean, especially toilets";
"I came two successive days, when I came the following day I found the very same mess from yesterday"

Poor cleanliness and hygiene and overcrowding of the maternity units including bathrooms have been reported in several studies (Hillan, 1999; Menon et al 2010 and Fawole, Okunlola and Adekunle, 2008). Menon et al further concluded that overcrowding and pressure of work may cause stress for midwives, which in turn might lead to them being insensitive and ignoring the needs of pregnant women.

Frustration

Most participants expressed anger and frustration. Anger was mostly associated with the insensitive care they received, withholding of information by midwives and the fact that they don't have time to address the women's concerns. Some women remarked:

"If you ask, they say, what are you saying? You are wasting my time. She says she is doing her work, she only have time to do her work?"

The above statement might imply that the midwife does not consider psychosocial care as part of her work. One participant further remarked,

"It seems like they are forced to come to work, sometimes you want to cry, you end up crying because you are hurting and that thing affects the baby"

5.4.3.6 **Women's ideal antenatal care**

Responses to the question asking women ways in which antenatal care could be made better for them were mainly suggestions relating to aspects which led to their dissatisfaction as indicated in Table 5.3.

An unrealistic comment by a woman with language problem;
"I would like them to help me, to teach me how to speak their language"

One participant addressed discrimination as follows:
"*mabasiphate ngo kulingana*" ***(Let them treat us equally).***
A plea for the midwife's attitude and response:
"*Baphathe kahle umuntu, babe ne smile*" ***(Midwives must treat a person right, with a smile).***
"*Kamogelo ya bona ko rona, ntho ya botlhokwa ke kamogelo*" ***(It is important for them to have a welcoming, approachable personality).***

Women needed good communication with midwives. They wanted enough information about the care that is given to them and be given an opportunity to ask for more information.
"*Ba re tlhalosetse ntho tse ngata like the very first time gao tlile, diinjections tse ba re tlhabang tsona"* ***(They must explain various things to us, particularly on our first visit, the injections they administer and so forth).***

A consistent and proper assessment was regarded as important*;*
"They should check us all the time, check that the baby is ok, first thing they should ask you if you are alright"

A need for additional support by other health care givers other than midwives;
"*Can there be someone who is always watching on everything that the nurses are doing. At least the government should put a social worker to observe how the nurses treat the women, especially those with labour pains*"

The general findings of the discussion with pregnant women are similar to most studies, old and current. (Reid and Garcia (1989);Williamson and Thomson (1996); Mozingo et al (2002) and Menon et al (2010).The aspects of care that the women were dissatisfied with within this study are similar to those raised, even from old studies. For example, findings in a study by Williamson and Thomson in England (1996) on women's satisfaction with antenatal care were lack of explanation (particularly regarding scans); the long waiting time to be seen and only to be rushed; lack of continuity of care, mainly in terms of an update on progress from the previous consultation; not knowing what to expect; lack of information based on not being told unless one asks; and language barriers.

Another study, by Reid et al (1989) showed that women's dissatisfaction was centered on long waiting times, impersonal care, poor communication and lack of continuity of caregiver. Similar themes emerged within this study. This implies that these factors are long-standing issues that need to be resolved.

Clarke viewpoint (1995),was that midwives act as oppressors by withholding information from those they are supposed to empower. The use of power by midwives is a form of control and a way of raising midwives' self esteem and prestige. This could be a direct result of the external control they feel exerted on them by policy makers, management and obstetricians. The question was therefore asked: "Is it because midwives feel so insecure or unsure of their

practice that they feel compelled to control those who are less informed?" The latter statement resonates with the findings of a global nursing research project by the International Council of Nurses (ICN) and Pfizer, conducted in 2009. Nurses (71%) indicated that third party payment organizations, care guidelines and government protocols limit the specific type of care they are able to provide to patients.

Menon et al (2010) revealed that there is evidence that women are reluctant to share their concerns about pregnancy and birth with the midwives. Several participants in the group discussion acknowledged that some midwives are kind, but some women experienced harsh treatment from some of the midwives. There is a prevailing impression that midwives were likely to be rude and outspoken, and this led to women being wary of asking questions or seeking advice. There was evidence that women did not feel confident about disclosing information to the midwives, similar to one respondent in this study,

"Like N, when you book, she cheeks you, I could not even call her aside and tell her that I have a problem, I once terminated my pregnancy because N will let everyone hear about your problem, and when you talk softly to her, she will shout and say is that how you speak to your mother, I was afraid and ended up telling her that this is my first pregnancy?"

5.4.3.7 **Conclusion**

While childbirth is a life-transforming event associated with satisfaction, self esteem, personal growth and the assumption of the parental role, it can also be associated with negative emotions like grief, guilt, disappointment and anger. These emotions are influenced by the woman's interaction with the health care providers (Mozingo et al, 2002).According to Dragonas and Christodoulou (1998), most studies emphasize the desire expressed by women for personal care, shorter waiting time, continuity of care, enhanced communication with health care practitioners, a greater opportunity for asking questions and receiving comprehensive answers, and a greater attention to their needs and fears. Focus group discussions with women in this study were generally in agreement with the latter.

5.5 **EXPERT INTERVIEW RESPONSES**

5.5.1 **In-Depth Interview Process**

In-depth interviews were conducted with midwifery experts. Experts within this study were individuals with advanced knowledge of the day-to-day management of pregnant women.Experts were selected according to the criteria as attached (Appendix G).

Purposeful sampling was used to select subjects who met the criteria from the universities, nursing colleges and the midwifery clinical sites within Gauteng province.

Those that accepted the invitation were interviewed. The interview guide consisted of nine open-ended questions (Appendix Q). Data saturation was reached with the fourth interviewee. Small tokens of appreciation were given to each participant at the end of the interview

The subjects interviewed were: an expert from a nursing college who in a published article had indicated her concern that women in South Africa are not yet fully empowered and cannot make decisions about their reproductive health; a Midwifery Department Manager froman Academic hospital who had extensive experience in midwifery practice and clinical facilitation; a University lecturer with more than 20 years of teaching midwifery; a midwife with an established private practice who was also a childbirth educator for 16 years and had an interest in the psychosocial aspects of midwifery care. The interview process ranged from 55 to 90 minutes for the four respondents.

5.5.2 **Findings**

5.5.2.1 **Viewpoints regarding psychosocial care**

All respondents regard psychosocial risk assessment and psychosocial support during pregnancy as a very important aspect of comprehensive antenatal care. See Table 5.4.

Table 5.4: The participants'viewpoint regarding psychosocial risk assessment and psychosocial support during antenatal care.

Respondent no.	1	2	3	4
Theme	*Its **important** but I don't think its assessed very well*	*It's **very important**, to try and establish a kind of bond with the patient; if possible extend beyond the patient to the partner*	***Extremely important**, throughout the process of childbirth*	*I honestly believe that this field that you are concentrating on is probably the **most important** because we have lost touch with the important signs of intuition and that is related to feeling and all the rest* *My observation is that there are individual people and some policy makers who really believe it should be done well* *The psychosocial includes everything, includes the disease pattern*

5.5.2.2 **The clinical application of psychosocial care by midwives**

When asked whether psychosocial assessment and care were adequately addressed, according to the participants it is very much neglected or addressed through “intuition”. The main focus on antenatal care is medical care rather than psychosocial care. In private hospitals, psychosocial issues are addressed to a certain extent but without a formal psychosocial risk assessment program. Each participant further elaborated on the factors that contribute to psychosocial care not being adequately addressed, with shortage of staff and work overload being common factors.

The medicalization of pregnancy and childbirth was a concern within this study as reflected from an in-depth interview with one of the midwifery experts:

“It’s good, but it’s sadly a neglected area and quite honestly… I believe that one of the main things that causes that is our very system, you know the hospital system, the clinic system, the whole medical system. It’s not the most ideal place when it comes to pregnancy, birth and baby care; because you know pregnancy is normal, birth is normal. It does not mean that there are no times when you have a high risk baby, or an emergency or you need medical care.

But we are so focused on that medical model that, I think the human touch gets lost, and one of my big concerns is that midwifery is no longer midwifery, it’s obstetric nursing and whether it’s antenatally, during birth , postnatally or even in those early baby care months and years, when the mommy gets to the clinic and so on, it’s such a medical model, and look I come from that background, it’s who I am by training. But I am really,really concerned that, in an effort to be perfect , technicians of medicine, we lose the heart and soul, and you know the things that are really important to pregnant women and mothers they don’t find or we have not learned about it in our training. But you know what, I would like somebody to come to me and say make that module, say a university or a college, because I think there is a need to return to the roots of nursing. You know the word nursing, it means take care, have patience, have love, see them through, you see it takes them a bit longer it’s not as easy as giving an injection”.

Two participants indicated that the antenatal card had no guidelines regarding psychosocial assessment. Fragmentation of the hospital system was also a source of concern, for example a maternity setup where a woman in labour is admitted in the admission ward, then moved to the first stage room and then transferred to a delivery room when her cervix is fully dilated. This disrupts continuity of care as the sections are staffed by different midwives.

Added to this situation is the nurses' shift systemwhich limits the woman's chance of being delivered by a midwife who progressed her during the first stage of labour.

Table 5.5: TheImplementation of Psychosocial Care

Respondent no.	Responses	Contributing Factors
1.	*"No, it's not adequately addressed…because sometimes you find that you have taught students certain things but it contradicts what is practised in the clinical.* *There is much more that we teach the students, but you know how it is, they learn from observation, so if the midwife in the antenatal clinic does not do it properly, the students also don't do it properly*…the *students are 90% in clinical, you get this snowball effect"* "*There is not much, there is actually no, nothing, no attention given to it, because we tend to focus only on the physical aspect…you must ask and observe how many times do midwives ask "how are you?" instead of asking "do you have any problems because our care is only problem based"*	Antenatal card part for social history very small Lack of multidisciplinary team in the primary health care clinics A focus on pushing the queue or numbers when doing antenatal clinics High number of patients Workload Shortage of midwives Time constraints Patients not being well- informed about their psychosocial side
2.	*"It's not always possible, but if you can, It's an important part of providing antenatal care. We try to incorporate it through history takingat the booking, get one on one opportunity,but what I find works well is health education most of the time at the end of it, for questions and answers* *They are not looking so much at the psychosocial problems although if a problem is picked up obviously they will approach a social worker…they are primarily concerned with the clinical visit and the physical wellbeing of mommy and baby* *The closest you can get to that will be booking in, you know when you talk to the patients and you get their past history"* "*They are knowledgeable when it comes to theory and that, you know, that is what should be done, and often it is done, but there are times when they feel under pressure…although they know this, they are not actually implementing this, but I think they are aware of it"*	Lack of time Limited midwives clinics Work overload Staff shortage No guidelines in the currently used antenatal card
3.	*"There is no interaction, no emotionalinteraction, and no psychological support* *Not addressed at all in government area* *The hospital itself is like a sausage factory* *supposed to happen in doctors room in a private hospital, but it's not* *Use of antidepressants with any sign of tearfulness post delivery* *Only possible in a private clinic with a private midwife"*	Lack of staff Lack of time Fragmentation (1st stage room and labour room)

Table 5.5 (continued)

Respondent no.	Responses	Contributing Factors
4.	*"It is a sadly neglected area* *We are so focused on the medical model that I think the human touch gets lost* *Midwifery is no longer midwifery it's obstetric nursing* *The things that are really important to pregnant women and mothers they don't find or we have learned about it on training but don't implement* *The western medical model talks about multidisciplinary approach, I still don't think that's good enough…every human being is more than the sum of her parts* *For me it looks like we are trying to make the woman's life more difficult instead of easier, we do it to our own gender, that's what I can't understand"* "*I am not seeing that and for me there is a different type, a wide neglect of patients is a very technical neglect, they are so focused on seeing the doctors while neglecting the human aspect, it's like chipping away a granite block"*	The hospital system, the clinic system, the whole medical system, not ideal for childbirth The shift system in hospital midwifery Nursing and midwifery chosen for wrong reasons Nurses claim to be badly paid

5.5.2.3 **The South African Nursing Council's perspective of psychosocial care**

According to most of participants, the South African Nursing Council Midwifery Education and Training curriculum reflects the need for psychosocial care, although in general terms rather than specifically, for example the broad concept of holistic care. The implementation depends on individual institutions to "unpack" the concept and plan and apply to their context.

Table 5.6: Psychosocial Care (SANC)

Respondent no.	Theme South African Nursing Council (SANC) curriculum	Scope of Practice (R2598) and (R2488)	Midwifery Training Institutions' curriculum
1.	*To a certain extent yes, there isn't clear guidelines*	*No, it does not,it only focuses on antenatal visits, on equipment that is necessary, on recordkeeping and things like the promotion of breastfeeding. R2598 touches on it a little bit but it does not focus on psychosocial aspect, as we would really need it to be done.* *The antenatal care policy is looking at medical risk, obstetric risks… it only looks on the physical aspect, it doesn't look at the psychosocial aspects*	*Mmm I don't think it is, it might be but not, there is not a lot of focus put on it because we only do psychosocial aspect when we do the initial visit…when we take the history and its only during labour and then in postnatal…but not too much is like we brush it off we don't focus on it and we don't spend a lot of time on it…its too much fragmented…what can I say, its compartmentalizing care…we don't look at it comprehensively and holistically.*

Table 5.6 (continued)

Respondent no.	Theme South African Nursing Council (SANC) curriculum	Scope of Practice (R2598) and (R2488)	Midwifery Training Institutions' curriculum
2.	*Yes, we have to look at the patient holistically, …especially a well patient*	*I can't comment on a sort of thing like that, but I am sure it does you know, but I don't recall, well it definitely should and I am sure it does*	*I think they do focus…, when I was training,we had to focus on that… we had to take one patient and follow her through, and obviously that was very important, in your assessment and the whole environment of the patient, the psychosocial aspect, we visited the patient at home, we interacted with the rest of the family. I cant give you the actual percentage of the curriculum…but it was definitely emphasized, you had to look at the patient as a whole*
3.	*Covered although there is more focus on physical needs* *Curriculum encompasses psychiatric training* *The interpretation lies within the scope of each individual institution* *A holistic approach interpretation should be done by the training institutions*	*It's written in broad terms, I think its addressed adequately* *The problem comes with the interpretation of the importance of it*	*Designed to meet psychosocial care, but not adequately taught in almost all institutions* *Time spent in class on teaching skills …I don't think it's adequately addressed*
4.	*It's much like individuals, is how you interpret what there is* *I must say probably the details of the curriculum, I am not sure*	*I believe the scope of practice is quite wide if you read between the lines* *In the private setting, you don't have so much power as a midwife* *I test everything against do I believe in what I am doing?* *Maybe I have an overdeveloped sense of ethics* *I don't know what the scope of practice is about and I don't know if I want to know* *I have an advisor that I always say to, if you think I am stepping outside the scope of practice would you please let me know?*	*Our biggest hope of radical change is making sure that the curriculum for midwives …is really woman-focused and is midwifery-focused and not obstetric-nursing-focused*

5.5.2.4 **Formative and summative clinical tools**

The following are responses regarding formative and summative clinical assessment tools on whether they include outcomes which measure or test psychosocial assessment and care?

Resp. 1"*Yes it does, we have psychosocial care in formative in Midwifery Nursing Science 200; in Midwifery Nursing Science 100 its only in summative…its only touched a little bit in antenatal care"*

Resp. 2:"*I don't think it's adequately addressed, students have to do research in the clinic, they often choose topics that are psychosocial for example HIV patient, that sort of a thing"*

Resp. 3:"*Yes, even in general nursing. I think it all depends on the individual educator and if that person feels very strongly about a certain aspect, it's emphasized and the students get more positive, and perhaps we should look at the educators themselves, and not only interpret regulations but also interpret how does she communicate it to the students"*

Resp. 4:"*We see students at the symposium, and I hear things, and I don't think it's well done"*

Psychosocial assessment and psychosocial support seem not to be effectively implemented by midwives during antenatal care, based on the following responses.

Resp 3: *"Exam papers ask questions on post partum-depression, but real competency skills …I don't think that's adequately assessed"*

5.5.2.5 **Midwives' opinion regarding research on psychosocial care**

The existing research, published or unpublished is mostly on physical or technical aspects of midwifery care and very limited in psychosocial care, which is commonly integrated with other disciplines. See Table 5.7.

Table 5.7: Research on Psychosocial Care

Respondent no.	Comments
1.	*"Most of the time it's about technical things, how do you assess, how do you interpret…but not focusing on mothers as such in the antenatal period"*
2.	*"But not in our own unit, in some areas, there is research being done, we have students doing some small research , you know if you look up, will find there is a lot of research on psychosocial midwifery care"*
3.	*"Quite a number of studies* *Psychiatric nurses who link to both midwifery as well* *But still I think it's not enough* *People need to be coached in doing research and that they do not think it lies within the discipline of psychosocial nursing but within the domain of a human being and perhaps we ourselves fragment the person too much"*
4.	*"I stay in touch with research, if I don't know something, I will go and research It is mostly the physiological but I think there and there you see somethingemerge which gives me a little bit of hope but I don't think it's enough, I think people still don't take it seriously"*

5.5.2.6 **Recommendations by participants**

Regarding recommendations for the inclusion of psychosocial assessment and psychosocial support during antenatal care, 75% of participants focused on nurse education and training, including redesigning the curriculum.

Resp. 1 "*We need to "conscientize" students about the importance of psychosocial care; students need to effect change in practice*"; The fact that basic midwifery program is offered through addressing low risk pregnancy at first year level and high risk pregnancy at second year level was a concern as reflected in this response: *"Yaah….yaaa…it is too muchfragmented because we don't look at , actually you know this thing of MNS 100 and 200 its, its, its , how can I say, its compartmentalizing care because the MNS 100 can easily move into MNS 200 because if the woman is not progressing during labour, she becomes a high risk patient, we should actually, not divide this as one woman can be a 100 and a 200 at the same time, …within the same situation age…because if you get a primigravidas or you get a woman in labour, she can easily develop obstructed labour or CPD and she is a 200, so for us to teach MNS 100 then MNS 200 is actually wrong, because the students should be knowing about the abnormalities of the intra-partum but its limiting us, …maybe that also has an impact in undermining other areas, because we are focusing on.. , you know sometimes I think because we have got different disciplines, women's health or midwifery, psychosocial, community, GNS and others, our mind set also says " why should I do it because the psychosocial lecturer should it, forgetting that the psychosocial lecturer is not a midwife and she is not going to be in*

contact with this woman .. . yaah…and what they also do with social science is that they tell you there is this in midwifery"

Resp. 3, "*To empower midwives through training, with a focus on the "Whole Theory Concept". A model for a bigger holistic South African approach for management of pregnant women to address the whole psychosocial needs, with HIV as well"*

Resp. 4, "*We probably have to start with the new student, through the generation again, maybe we can rescue it, The emotional is as important as the whole woman, if the students were taught in that way from the very beginning, the curriculum should be woman focused, a module for psychosocial care should be designed"*

All participants emphasized the importance of applying psychosocial care in clinical practice. Resp. 2, "*A one-on-one visit for every woman, education talks"*;
Resp. 1 "*Midwives in practical training should also be part of this,identify the women at risk, gender sensitivity / women's preferences"* Resp. 4*, " Help health professionals to understand what women really want. Midwives need to be calm, and show women real care and compassion and take control of the situation"* The importance of the dissemination of research regarding psychosocial care was also highlighted*, "Articles need to be taken to maternity groups and to conferences"*

5.6 CONCLUSION

Chapter 5 presented qualitative findings based on the researcher's informal conversations with pregnant women, midwives and women focus group discussions and responses from expert's interviews. The findings revealed that both the midwives, midwifery experts and women are of the opinion that psychosocial care during antenatal care is overlooked. Though midwives regard psychosocial care as a crucial part of antenatal care, it is mostly offered through intuition as there are challenges that prohibit them to implement psychosocial care.

CHAPTER 6

6. THE INTEGRATION AND DISCUSSION OF QUANTITATIVE RESULTS AND THE QUALITATIVE FINDINGS

6.1 INTRODUCTION

Chapter 6 describes and discusses the study results in detail by grouping the findings to the corresponding quantitative and qualitative sub-questions related to emerged themes. Quantitative and qualitative data were initially analyzed separately to develop an understanding of the two databases before merging the findings and results. Quantitative results were first interpreted to help answer the study's quantitative questions (chapter 4), then the case study findings that were aimed at answering research questions in the qualitative phase of the study (chapter 5). The process provided separate and independent results that could be compared for the purpose of corroboration, complementarity and discussion. Results were compared for specific content areas, for example major themes.

The integration was put together by way of meta-inference, interpretive agreement, population transferability and by applying the similarity contrast principle. Data integration was based on the purpose and the objectives of the study, qualitative and quantitative research questions and the rationale for using mixed methods. The discussion is augmented by citing related literature and reflecting on qualitative and quantitative published studies addressing psychosocial care.

6.1.1 Quantitative and Qualitative Data Sources

Figure 6.1 provides a summary of quantitative and qualitative data sources from which data were obtained and integrated.

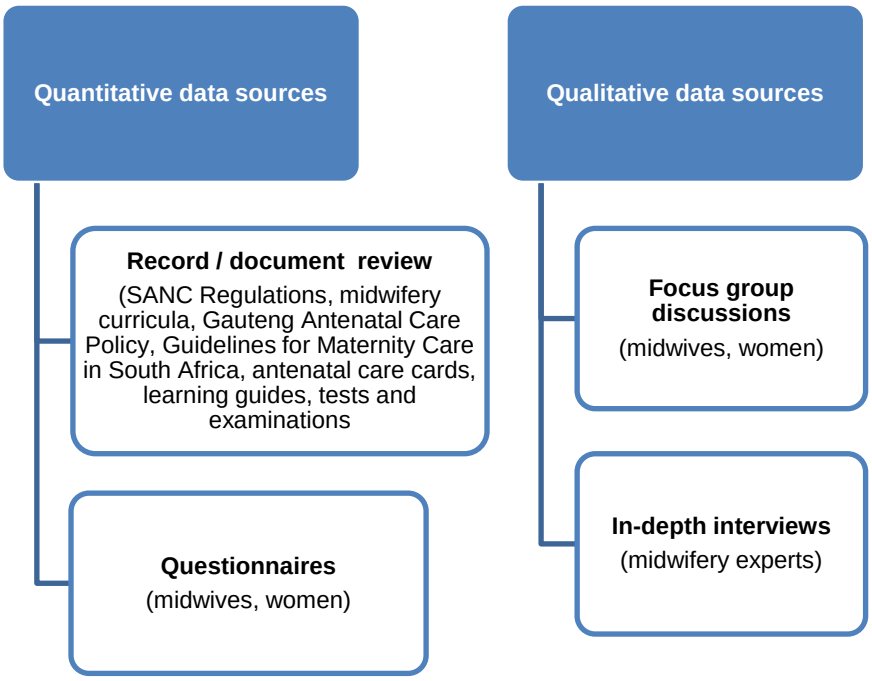

Figure 6.1: Quantitative and Qualitative Data Sources

6.1.2 Mixed-Methods Background

Quantitative and qualitative methods were used sequentially. The rationale for using mixed methods for this study was: (a) to obtain a better understanding of psychosocial risk assessment and psychosocial support during antenatal care, through converging numeric trends from quantitative data with specific details from qualitative data; (b) to develop variables or constructs that need to be addressed in psychosocial risk assessment; (c) to convey the needs of pregnant women; (d) the fact that mixed method is the most appropriate for psychosocial studies to obtain greater diversity of views (Crump and Logan, 2008); (e) the representativeness and generalizability of quantitative results and the in-depth and contextual nature of qualitative findings (Hanson et al, 2005); (f) the combination of qualitative and quantitative questions which were best answered through a mixed research approach and; (g) to incorporate the strengths and overcome the weaknesses of both quantitative and qualitative approaches

Data were grouped according to the qualitatively explored and quantitatively explained subsections relating to psychosocial assessment and psychosocial care.

Quantitative questions

- To what extent is psychosocial care included within the South African Nursing Council midwifery regulations and midwifery education curriculum?
- Do the Gauteng Antenatal Care Policy guidelines include psychosocial risk assessment and psychosocial care during antenatal care?
- Are midwifery students theoretically and clinically instructed about psychosocial assessment and psychosocial care during midwifery education?
- Are midwifery students theoretically and clinically assessed on psychosocial risk assessment and psychosocial support during midwifery education?
- To what extent do pregnant women present with psychosocial risk factors during antenatal care?
- Do midwives conduct psychosocial risk assessment during antenatal care?
- Do midwives provide psychosocial support during antenatal care?

Qualitative questions

- What are the perceptions of midwives regarding psychosocial risk assessment and psychosocial care during pregnancy?
- What are the experiences of pregnant women regarding psychosocial assessment and the psychosocial support offered by midwives during pregnancy?
- What are the perceptions of midwifery experts regarding the content and quality of psychosocial care within midwifery education in South Africa?
- Do midwifery experts consider psychosocial risk assessment and psychosocial support an important aspect of the management of women during antenatal care?
- What are the perceptions of midwifery experts regarding the psychosocial management of pregnant women?

These questions are linked to the study objectives and were addressed through quantitative and qualitative data collection methods that are described under the methodology chapter.

6.2 MIXED-METHOD ANALYSIS

6.2.1 Introduction

Multiple strategies for mixed method analysis were used in this study. The techniques that were applied are case oriented and variable oriented analyses as described by Onwuegbuzie et al (2009). Strategies that were used were merging quantitative and qualitative data through discussion, through a matrix, by data transformation, and through data interpretation(Caracelli

and Greene, 1993; Creswell et al, 2003; Bryman, 2006; Creswell and Plano Clark, 2007; Plano Clark, Garrett and Pelecky, 2009). Merging through a discussion facilitated interpretation of results by comparing findings from the two methods, a matrix explored differences in quantitative and qualitative categories at the level of results, and data transformation addressed data from both quantitative and qualitative perspectives that could indicate a new variable with further analyses and occurred at the level of data analyses.

The fundamental principle of data analysis, as described by Onwuegbuzie and Lee (2007) and Onwuegbuzie et al(2009), was applied to this study. They describe four major types of generalization applied by mixed methods researchers as external and internal statistical generalization, analytic generalization, case-to-case transfer and naturalistic generalization.

6.2.2 **Case-Oriented Analyses versus Variable-Oriented Analyses**

Case-oriented analyses are analyses that focus primarily on selected cases to interpret perceptions and opinions of participants, whereas variable-oriented analyses are conceptual and theory-centered and involve the identification of relationships. Case-oriented are applicable to qualitative data but can also be used in quantitative approaches. Variable-orientated analyses can also be used for qualitative data, for example examining themes that cut across cases, that, within the context of this study, could be between different focus group discussions or themes generated from the review of multiple documents and records (Onwuegbuzie et al, 2009).

The combination of case-oriented and variable-oriented analyses led to a two-dimensional representation of findings and results as reflected in Figure 6.2.(Onwuegbuzie et al, 2009). The vertical axis represents the quantitative phase with variable-oriented analysis on one side and case-oriented analysis at the opposite end. The horizontal line represents the qualitative phase with variable and case-oriented analyses located at opposite poles. Quadrant 1 reflects variable-oriented analysis for both qualitative and quantitative data. Quadrant 2 reflects variable-oriented analysis for quantitative data combined with case-oriented analysis for qualitative data. Quadrant 3 reflects variable-oriented analysis for qualitative data combined with case-oriented analysis for quantitative data. Quadrant 4 reflects case-oriented analysis for both qualitative and quantitative data.

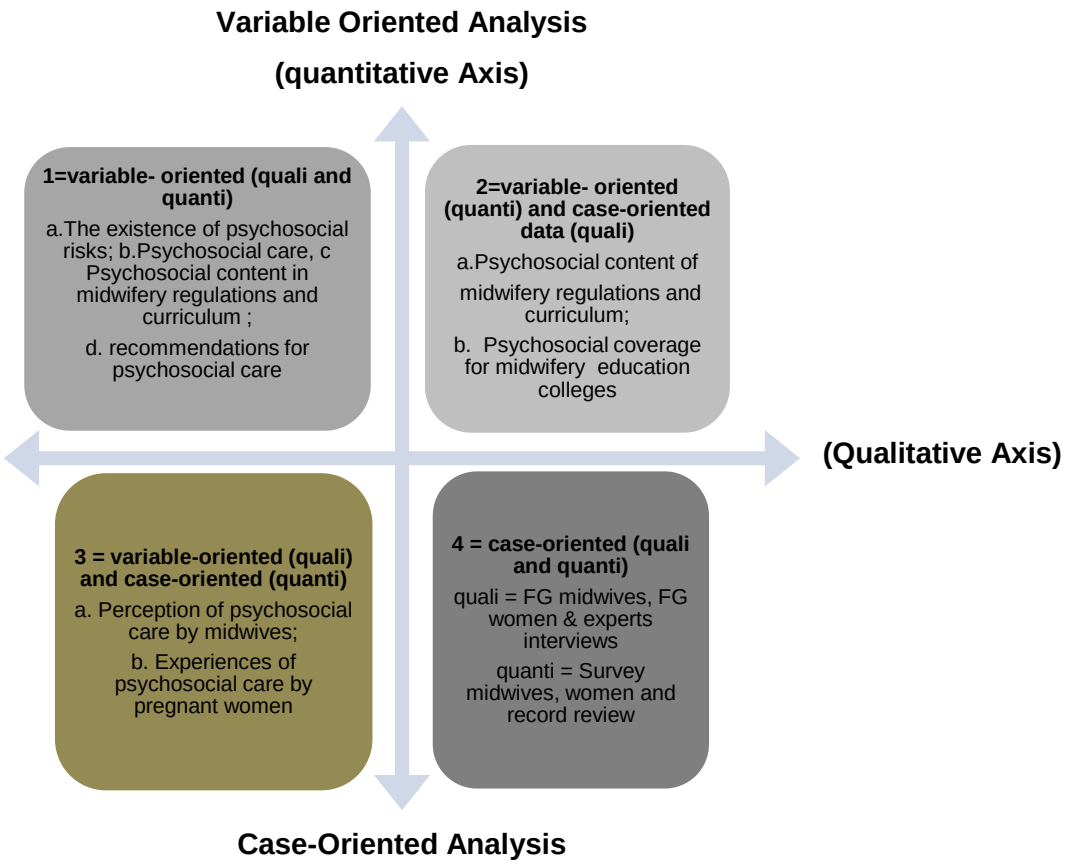

Figure 6.2: A two-Dimensional Representation of Variable and Case Oriented Analyses

6.2.3 Case-Oriented Analysis

Case-oriented analysis, according to Onwuegbuzie et al(2009), focuses on the selected cases as data sources. The goal of case oriented analysis within this study was to analyze and interpret the perceptions of psychosocial care by midwives and midwifery experts, furthermore, to establish the experience of pregnant women regarding psychosocial care during pregnancy.

The qualitative data cases are:

- three focus group discussions held with midwives;
- four focus group discussions held with pregnant women and
- four in-depth expert interviews.

Quantitative data cases:

- survey conducted on South African midwife delegates attending an annual Midwifery Congress;

- survey administered to women attending antenatal care at selected clinics;
- the reviewed antenatal cards of women attending the selected clinics;
- the reviewed midwifery education records;
- Midwifery education and regulatory documents obtained from the South African Nursing Council

6.2.4 **Variable-Oriented Analysis**

Variable-oriented analysis, as discussed by Onwuegbuzieet al (2009), was conducted through the development of themes across qualitative and quantitative data. Themes were based on the purpose of the study, the objectives of the study, the qualitative and quantitative questions and the findings and the results of the study.

Quantitative variables

- Theextent of psychosocial risks during pregnancy in this population;
- Theinclusion of psychosocial care in the South African Nursing Council Midwifery Regulationsand the curriculum for Midwifery Education as mandated by SANC and expressed in the curriculum of the Nursing Colleges in Gauteng Province;
- Theinclusion of psychosocial care in the training of midwives in the Nursing Colleges in Gauteng Province; and
- Psychosocial care guidelines for practicing midwives as stipulated by the Gauteng Antenatal Care Policy (1997).

Qualitative variables

- Theexperiences of psychosocial care by pregnant women who attended antenatal care at the three clinics selected for the study;
- Theperception of psychosocial assessment and care by midwives offering antenatal care to the women at the three clinics;
- Theperception of psychosocial care by midwifery experts based on in-depth interviews; and
- Recommendationsfor psychosocial care by midwives in the clinics, midwives at the Midwifery Congress and midwifery experts.

6.3 THE ANALYSES OF VARIABLES

6.3.1 The Extent of Psychosocial Risks

The objective was toestablishthe existence and extent of psychosocial risks experienced by women duringpregnancy and as perceived by midwives in their care**.** The objective was explored quantitatively through the review of antenatal cards, the administration of a questionnaire for pregnant women at three antenatal clinics and a self-reported questionnaire distributed to delegates at a midwifery congress in South Africa. The existence of psychosocial risk was qualitatively explored by conducting focus group interviews with midwives working in the antenatal clinics, women attending antenatal care where the study was conducted and individual interviews with midwifery experts.

Psychosocial problems experienced by pregnant women were reflected by responses to questions on their emotional status during the current pregnancy, perceived social support and work environment, experiences of family violence and of stressful life events. The midwives survey responses were established from a question that asked them to list the psychosocial risks/problems they encountered during the management of a pregnant woman. The antenatal cards were reviewed for the assessment of midwives' recorded psychosocial risks and psychosocial care.Quantitative and qualitative responses on psychosocial risks are merged as in Figure 6.3.

QUANTITATIVE results (women's survey) =the responses reflected that 20% of women stated that it was difficultto accept thepregnancy, 20% felt isolated and lonely. Women lacked transport to the clinic (54%),29% either themselves or their partner used alcohol, tobacco or other drugs, 48% experienced intimate partner violence. For 54%, the pregnancy was unplanned.

(midwives survey) =the respondents citedthe following as psychosocial risks or problems they experienced:teenage pregnancy (56%), HIV/AIDS (54%), poverty (42%); unemployment (35%); unplanned pregnancy (25%); unaccepted/ unwanted pregnancy (30%).

(antenatal cards) = the reviewed antenatal cards revealed unmarriedpregnant women (22.5%) unemployed (18.8%) and HIV/AIDS positive (20.8%).

QUALITATIVE findings (FGI midwives) = The responses from the midwives focus group discussion was reflected as follows: "anything that is affecting a woman socially as a human being"; " The stigma associated with HIV/AIDS"; "Some lack accommodation and employment"; "Social background, home situation and financial support". "A divorced woman"; "How does the woman feel about the pregnancy?" "Psychology talks about mentality, psychological."

The common psychosocial problems that the participants encountered were HIV/AIDS; unemployment; lack of accommodation; no family support system; smoking and alcohol consumption; teenage pregnancy and poverty.

Figure 6.3: The Existence of Psychosocial Risks from the Quantitative and Qualitative Perspectives

There is an indication of psychosocial risks or problems from both quantitative and qualitative responses. The common problems listed or raised by participants were unplanned pregnancy, teenage pregnancy, poverty, smoking, alcohol use and HIV/AIDS. Poverty was further clarified as unemployment, lack of transport and lack of accommodation. The prevalence of HIV/AIDS was a concern as reflected in the midwives' focus group discussions. It was also raised in self-reported questionnaires by women and a 54% response from midwives' survey indicated HIV/AIDS as an issue.

HIV/AIDS as a concern reflected throughout focus group discussions with midwives and within each question explored (5.3.2.2).The midwives survey (Table 4.14) also revealed that HIV/AIDS is more common with ahigh incidence in pregnancies of 18 years and below, commonly related to sexual abuse.

The World Health Organization (WHO,2003)'s psychosocial assessment and psychosocial support guidelines that were developed from an extensive academic literature review and the review of United Nations publications, could be adapted and applied within the context of this study in relation to the findings regarding HIV/AIDS during pregnancy and childbirth. The focus of the guidelines is on the individual, the couple, the family and communities who are infected or affected by HIV/AIDS during pregnancy.

HIV positive women may join self-help groups like "Wola Nani", which means "**we embrace and develop each other"**which is based in Cape Town, South Africa, and offers support to HIV positive women who are in need. Wola Nani established a self-help program in Soweto and Potchefstroom as a form of support. Its success is evidenced by the fact that 85% of women accessing its services are referred from antenatal clinics, which indicates a dire need for psychosocial care and that at least some clinics recognize the psychosocial problems in these women. Enrolling pregnant women in the Mothers 2 Mothers program is recommended in order to have better understanding and greater acceptance of psychosocial interventions (Aunt, Besser and Mbono, 2006).

Minnaar and Bodkin (2009), in a study exploring bereavement and grief in HIV positive pregnant women, found that women went through the usual emotions such as denial, anger, bargaining, depression and acceptance. Their conclusion and recommendation was that over and above the standard HIV program, midwives should allow women to share their feelings

about the disease, provide information regarding counselling, support women and offer care based on individual needs.

HIV/AIDS is considered by several authors for example (Marchal, De Brouwere and Kegels, 2005; Shisana et al, 2002; Bester and Engelbrecht, 2009). as a factor contributing to the growing shortage of nurses in South Africa as it increases demands on human resources,lead to burn-out and also accounts for health workers' HIV/AIDS morbidity and mortality

6.3.2 The Psychosocial Component of Midwifery Education

The objective was toexplore the content designed to educate and facilitate students regarding psychosocial assessment and psychosocial care of women during pregnancy. The objective was met through the review of the South African Nursing Council (SANC) midwifery curriculum, midwifery regulations (R2598, R2488, R427 and R387), the three Gauteng Nursing College's midwifery curricula, the midwifery learning guides, clinical tools used for midwifery education, tests and examinations written by students and a survey of midwives regarding psychosocial care. Interviews with midwifery experts were conducted to explore their perception of psychosocial midwifery education content.

Figure 6.4 outlines the findings and the results of the review of documents used for midwifery education and facilitation.

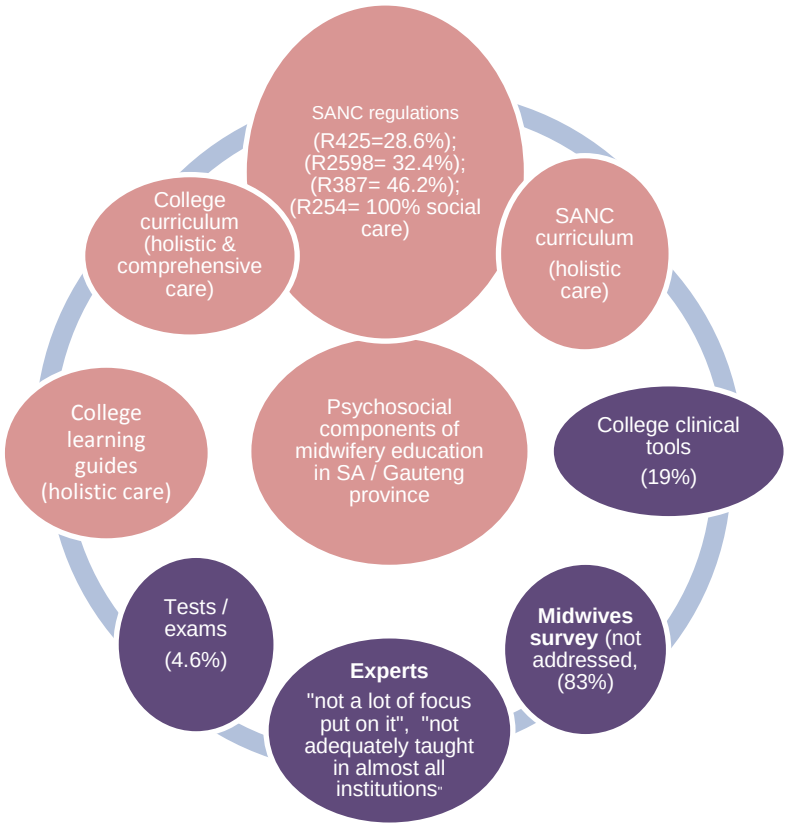

Figure 6.4:The Psychosocial Component of Midwifery Education in Gauteng Province (SA)

The key concept with psychosocial care as reflected in the SANC curriculum, the Nursing Colleges curricula and learning guides is holistic care. Holism, as explained by Patterson(1998), implies that “the whole is greater than the sum of its parts”. Nursing has been embracing holism to a varying degree throughout its history. Tierney (2006) is of the opinion that a health care practitioner who believes in holism often offers an alternative form of health care. A holistic philosophy, as applied to antenatal care involves a focus on the whole pregnant woman, her body, mind and spirit. The SANC Regulations address psychosocial care to a reasonable level as reflected within Figure 6.4 compiled from data obtained through the review of regulations.

There is evidence of a limitation of psychosocial content within the theoretical and clinical facilitation and assessment of student midwives, with 19% of psychosocial content covering student assessment in clinical care and 4,6% covering written psychosocial assessment as reflected from the review of clinical tools, tests and examinations administered over a five year period. The response from both the midwives’ survey and the experts’ interviews is that

psychosocial care is generally not adequately addressed across midwifery care. Refer Figure 6.4.

The above findings imply that the focus for clinical practice is 81% physical care versus 19% psychosocial care, and 95,4% covering physical aspects of pregnancy and only a 4,6% focus on the theoretical evaluation of psychosocial care in midwifery. In the midwifery survey 83% indicated that psychosocial care is not addressed. This implies a serious limitation on psychosocial care. One respondent in the survey further elaborated that "*I was trained in Belgium, we had to write separate exams on psychology, social and communication skills for midwifery. When I wrote SANC exams I found that this was seriously lacking"*

6.3.3 Psychosocial Care Guidelines for Midwifery Practice in South Africa

The guidelines are reflected within the South African Nursing Council Midwifery curriculum, the Gauteng Antenatal Care Policy (1997) and the Guidelines for Maternity Care in South Africa (2007). A concern regarding psychosocial care guidelines was raised in focus group discussions held with midwives and the in-depth interviews conducted with midwifery experts. Figure 6.5 illustrates the findings from qualitative and quantitative data sources.

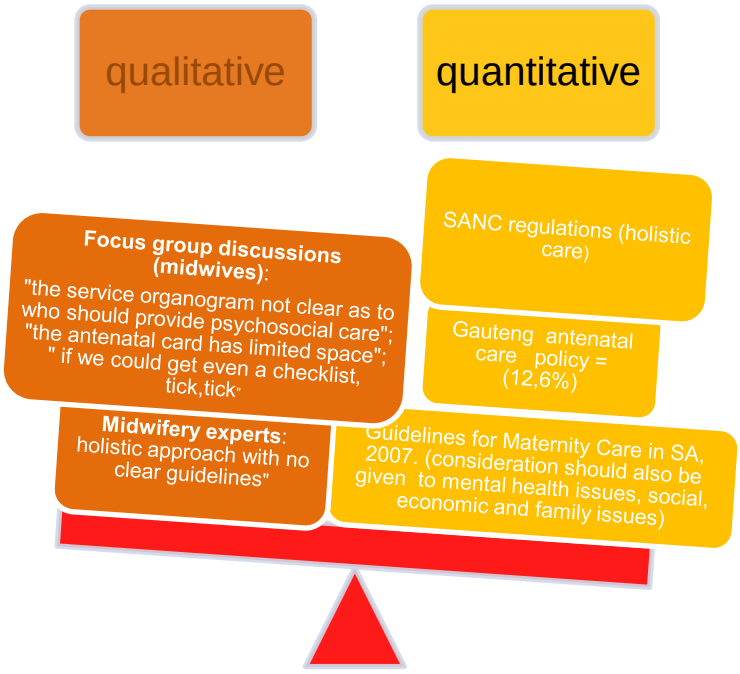

Figure 6.5: Psychosocial Care Guidelines

The SANC curriculum does not quantify the percentage of the course which should address psychosocial care as in the Regulations but focuses on holistic care throughout. A statement from the Guidelines for Maternity Care in South Africa (2007) also reflects a holistic approach to midwifery care. The psychosocial guidelines in the Gauteng Antenatal Care Policy (1997), comprised of 12,6% of the contents with 87,4% focusing on the physical aspect of pregnancy.

The midwifery experts' viewpoint was that there are generally no clear guidelines regarding the psychosocial aspects of midwifery care. At the clinical level, midwives who took part in focus group discussions indicated that theirdescriptions do not specify who should offer psychosocial care or how to conduct it. Another concern raised by midwives was that the existing antenatal card does not reflect any guidelines on what to assess, elicit or enquire about antenatally to determine psychosocial problems or risks.Furthermore, the antenatal card does not offer adequate space for documenting psychosocial assessment or psychosocial interventions.

In conclusion, guidelines for psychosocial care are not clear from the South African Nursing Council perspective, the Gauteng Antenatal Care Policy Document, or the Guidelines for Maternity Care in South Africa (2007). This lack of clarity was supported by responses' from midwifery experts, the midwives' focus group discussions and the midwives' survey.

6.3.4 **The Perceptions of Psychosocial Assessment and Psychosocial Support**

The objective was firstly to explore and describe the awareness and knowledge of psychosocial risk assessment and psychosocial care by midwifery care providers during pregnancy, and secondly to explore and describe the experiences and satisfaction of pregnant women regarding psychosocial care offered during antenatal visits.

These objectives were achieved through the review of 302 Gauteng Department of Health Antenatal care cards carried by women during their antenatal visits, and the midwifery survey which had a response of 202 questionnaires. Qualitative data were obtained through focus group discussions with midwives in clinical practice, focus group discussions with women attending antenatal care, and in-depth interviews with midwifery experts. Figure 6.6 presents the perceptions of psychosocial care from quantitative and qualitative data.

QUANTITATIVE = {midwives survey ⇒ (moderately addressed = 52.9%); (not at all addressed = 14.9%)
{antenatal cards ⇒ (unmarried, unemployed, HIV/AIDS positive = 27%)

QUALITATIVE =[Focus group discussions with midwives (positive responses)] "we should assess them in totality, viewing their mental state, physical state and social state they find themselves in" ; "we should include Maslow's Hierachy of needs".

(negative responses) "We are normally happy that the woman is pregnant but we do not ask about how she feels" ; "psychosocial care occurs by way of intuition..

[FGI women (negative responses)] "she just listened, but did not respond"; "if you ask, they say "what are you saying, you are wasting my time"; "yes, she says she is doing her work, she only have time to do her work"

Experts in-depth discussions="its not adequately addressed...."they are not looking so much at the psychosocialproblems although if a problem is picked up obviously they will approach a social worker...they areprimarily concerned with the clinical visit and the physical wellbeing of mommy and baby". "there is no interaction, no emotional interaction and no psychosocial support"; "it's sadly a neglected area, we are focused on the medical model that I think the human touch gets lost" "the Western medical model talks aboutmultidisciplinary approach, I still don't think that's good enough...every human being is more than the sum of her parts"

Figure 6.6: The Perception of Psychosocial Care

Psychosocial care seemed to be generally inadequately addressed as expressed by the focus group discussions with both midwives and women, the in-depth interviews with midwifery experts, the midwives' survey, and the inadequate reflection of psychosocial care on the antenatal cards.The major factors that seemed to contribute to inadequate psychosocial assessment and psychosocial support as perceived by midwives are indicated in Table 6.1. The themes were derived from midwives focus group discussions and from the midwives' survey responses to open-ended questions.

6.3.5 Factors that Contribute to Lack of Psychosocial Care

The qualitative responses of the participants that resulted from open-ended questions were explored and analysed using content analysis. Analytic categories representing factors that contributed to lack of psychosocial care were generated.

Table 6.1: Factors that Contribute to Lack of Psychosocial Care of Pregnant Women by Midwives

Contributory Factors	Midwives Survey (Quantitative)	Midwives Focus Group (Qualitative)
Work overload/ lack of time	(n=43) 19,4%	"I think we need more space, more staff because if the queue is long outside, with the client that you are having, you shorten the problem the assessment and youdo not address the problem because of time." " I think the way we are so overworked in this clinic, they even think that this is the hospital, they refer each other, and the number of nurses is really very, very low, but in spite of all that , as we attending to all the things, being so few."
Shortage of midwives	(n=41) 18,5%	"I think it can be done, there might be a challenge of the number of staff against the number of patients because you have to give full attention to that person when she talks instead of rushing the queue, so why I am saying this is that we might prevent some of the complications or some of the problem that recurs... we think it can be possible only if the ratio of staff and patients is corrected" ... "And to add to what she is saying, so its true if we can be more, I think we can be powerful, we can attend to the women."
Attitude of midwives, ignorance, lack of passion, disregard	(n=32) 14,4%	"As professionals working with women, there are also attitudinal issues from the professionals …from the clients also, that becomes a barrier.**Is this from both parties?(researcher)** Yes (from all) attitude from both because the patient will come with a problem anticipating a solution or looking out for a particular solution and the conflict now maybe the professional is advocating for a different solution, you see now the problem... the patient comes with an attitude, has a problem but comes with an attitude then the professional will also have an attitude... I think there is another option, another way of looking into this…"
Lack of infrastructure / referral resources	(n=24) 10,8%	"We have got a lot of patients with psychosocial problems, then for me personally I find that I am helpless and get frustrated because we cannot change that or we cannot sometimes assist them in the way that we can, our best way... therefore sometimes you don't know what help can you give because you will find that even the social workers will tell you, we don't have food parcels that we can be able to give to them to eat" "The structure is not in place..the structure is there, but the availability of the social worker, the person, it's a person! (emphasising) human resource,do you understand,the structure is there ..this is social service…but when you go to that office you wont even get any help"
Inadequate midwives training / skill incompetence	(n=26) 11,7%	"The organogram is also not clear as to what to do"
Inadequate or lack of communication	(n=7) 3,1%	"I think we can help them by being open, you know sometimes you are closed, they cannot communicate with you .What I realized is this every morning, when they are waiting outside, waiting for you to open the door, greet them, just make a joke, share a joke with them ... that will allow them to open up, once you share those topics with them, they open up and share their problems". "Not being able to communicate because of language barrier...some are speaking French, you can't, they don't hear English, they will just say I am speaking French, we do the sign language but it's a challenge... and from Malawi we expect them to speak English, but they speak those ones they inherit, can't speak any other language …so historytaking and assessment, psychosocial is a challenge.

Table 6.1 (continued)

Contributory Factors	Midwives Survey (Quantitative)	Midwives Focus Group (Qualitative)
Focus is on routine physical care	(n=8) 5,8%	"One other thing is that you know sometimes you get clients , we get attached only to this pregnancy, we don't ask about other things, you know its human... but do we ever really make time to ask how are you feeling? (emphasizing) are you happy about this pregnancy? You know , sometimes there are certain situations that the mother might be angry, they are not happy about the pregnancy, maybe it was a case of incest, we never ask (emphasizing), you know we are always happy about the pregnancy and we forget about the individual…"
Guidelines on antenatal care	(n=2) 0,9%	"What comes to my mind as a recommendation is lets have the guidelines on psychosocial care…. even if cannot be implemented now is for the future, let it be incorporated into antenatal care, even if it can be how small it will make a difference, you know to say what type of questions to ask...the antenatal card should be made in such a way that we can write the problems". "Definitely yes because, if you look now the state of affairs of our antenatal card its just social.. SMAAAL…(emphasizing) , it just says social, and you can ask anything, but if it's something that is practised... say social you indicate, psyche you indicate even with the admission.... our own admission bedletters, there is no where where psychosocial issues are recorded" 'There must be a tool because on the green card is just a small line, where we ask for example, it's not written clear, just says "social" therefore with us we say, we ask the question "are you working? And if she says yes is ok and if she is not working we ask her who is supporting you currently. And if she says my friend, boyfriend, mother or whoever, therefore you write " mother supportive". It is just a small line, therefore if there was a guideline regarding whatever done it will be appropriate for the pregnant women regarding social work or accommodation.
Holistic care	(n=16) 7%	"I think as one of us has said that you must assess a person in totality, not just the pregnancy part, but psychologically, physically, socially and emotionally, that is important, that is why it must be assessed …"
Management support	(n=13) 5%	"I think I can share you know to relieve the conscious you know, to get support somehow because sometimes there are things that you cannot carry them yourself alone, you need support and consolation from managers"

Reflecting on Table 6.1, shortage of midwives and work overload ranked highly accounting for 38% of the responses. Demanding workload was the most frequently reported factor contributing to dissatisfaction (28,7%) in a study by Bester and Engelbrecht, (2009) on professional nurses' job satisfaction and dissatisfaction. A general lack of resources (15,8%), for example and infrastructure of facilities including ambulance services were also observed in this study (10,8%).

The shortage of nurses is a chronic and widespread problem (Kaufmann, 1999; Woodward, 2000; Valentine, 2002). Khanyile (2011) in an editorial stated that on average there are 383 nurses per 100 000 people in South Africa according to the South African Nursing Council report. This statistic confirms the midwife shortage and work overload which compromises the

quality of midwifery. In an attempt to minimise the shortage of midwives, the South African President's recently announcement the revitalization of 105 nursing colleges which were closed a decade ago due to lack of funding, although this might be a long term project.

A response from the midwives' survey (*n*=5), as reflected on page 107(Table 4.14 under "resource-related factors"), was that another factor contributing to women not being psychosocially assessed and cared for was the non-supportive leadership or management in midwifery units. The limited number of midwifery leaders may also be attributed to the general shortage of nurses, as a shortage of nurses seems to be a problem at all levels of nursing. Maboko (2009) conducted a study on leadership in an academic hospital in Gauteng Province. The study by Maboko's interview guide was based on Maxwell's (2005) framework of leadership that focuses on relationships, equipping, leadership and attitude. The study revealed that the managers in this particular hospital were autocratic, which is a dysfunctional form of leadership that often renders managers ineffective and leads to resentment amongst staff.

Based on the midwives comments on lack of leadership and supervision, these findings could be applied within the context of this study. Bester et al (2009) further identified that a lack of communication, recognition and acknowledgement of nurses by managers was reported as a stressor (14,9%), with comments reflecting that they were excluded from decisions that affect their work environment, similar concerns were expressed by midwives within this study.

6.3.6 **Psychosocial Interventions by Midwives once a Psychosocial Risk was identified**

Figure 6.7 reflects a double helix presentation of psychosocial interventions by midwives derived from quantitative data (midwives' survey) and the qualitative data (focus group discussions with midwives). It describes qualitative themes and the frequency of quantitative responses in percentages for the same theme.

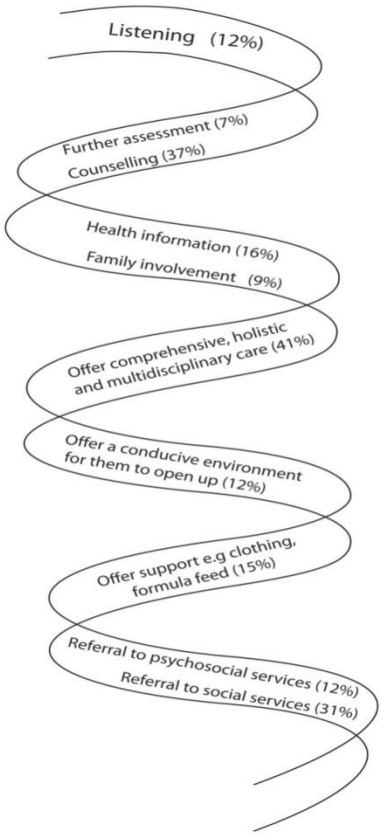

Figure 6.7: Psychosocial Interventions by Midwives

The interventions that were implemented by midwives once a psychosocial problem or risk was identified include most forms of psychosocial care. The interventions applied by midwives in this study are supported by other studies. For example Lavender and Walkinshaw (1998) in a randomized trial on whether midwives can reduce postpartum psychological morbidity, concluded that the most useful psychosocial support that midwives can offer to women during childbirth is “listening, support, counselling and explanation”.

Maputle (2010), in a qualitative study on women’s experiences of childbirth, identified psychosocial care themes like mutual participation, information sharing, informed choices, open communication and listening. Family involvement, which accounts for 9% in this study and is a form of psychosocial support, was also recommended by Handley (2006) in a correlational study on emotional response to pregnancy. The recommendation was based on the fact that the involvement of a family member in managing a woman during pregnancy strengthens the woman’s understanding of pregnancy and the development of trust in health care providers.

6.3.6.1 **A literature review of approaches to enhance psychosocial care during pregnancy**

6.3.6.1.1 **The Schindler-Rising model of "centering pregnancy"**

The Schindler-Rising model of "centering pregnancy", one of the recommended models for antenatal care, is presented in Figure 6.8

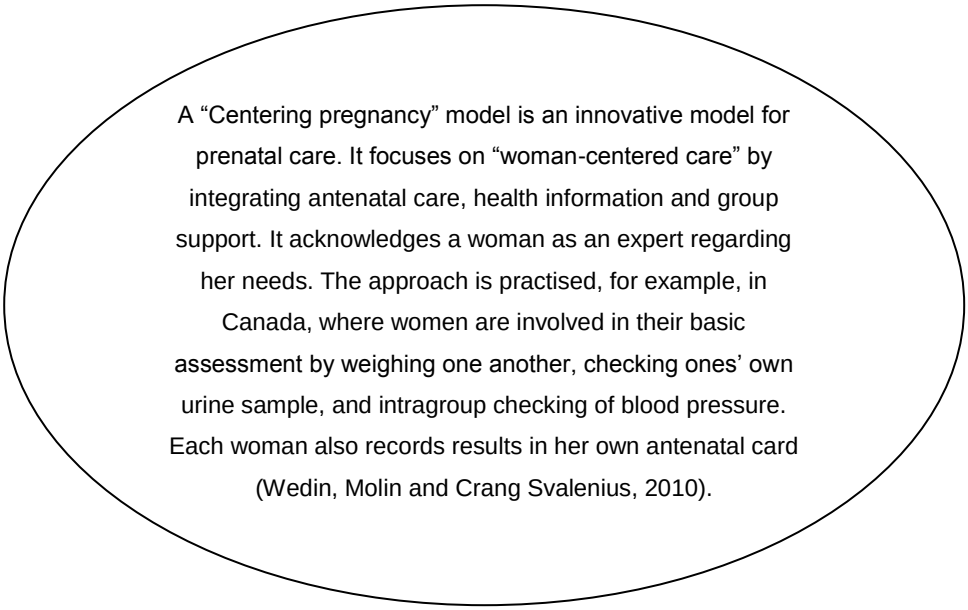

Figure 6.8: "Centering Pregnancy"

Although the "centering pregnancy" model might free midwives from routine investigations and as such allow them more time to address issues like psychosocial care, it carries a limitation in a sense that women should be literate, and the process should still be supervised by a midwife until women are familiar with all aspects.

6.3.6.1.2 **Group antenatal care**

Based on the shortage of midwives reported in this and other studies, and coupled with a limitation in psychosocial care, group antenatal care might be another option.

Group antenatal care originated a decade ago in Minnesota, USA during the early 1970's. It was introduced in Denmark in 1998, followed by Sweden in 2000. It is offered concurrently with traditional antenatal care.Antenatal visits are carried out in groups of 6 to 8. There is evidence that this approach increases networking between pregnant women, women are able to validate and sort information within the group, and it also allows a midwife to devote more time to pregnant women by saving about three hours per woman(Wedin, Molin and Crang Svalenius, 2010). Groups may address common

psychosocial problems, and those who need further individual consultation can be offered such, which will probably not be as often as with routine individualized care.

6.3.6.1.3 **Hawaiian-style "Talkstory"**

With South Africa being a multicultural country, a Hawaiian-style "talkstory" could offer an ideal approach in offering culturally-focused antenatal care as it is a culturally-based interactive communication approach, aimed at addressing the pregnant woman's psychosocial needs. It could be mostly effective during the initial antenatal care booking as the woman is taking the lead in sharing her childbirth experiences.

A Hawaiian-style "talkstory" originated from a needs-assessment project undertaken in Hawaii during 2000, where women indicated that their psychosocial needs were largely unmet. It is integrated into the woman's antenatal and postnatal assessment and care and involves an exchange of thoughts between the woman and midwife. It is based on the woman's values, beliefs and experiences, acknowledging custom and culture.

Figure 6.9 explains the talk story process as a guideline for midwives who might be interested in its implementation.

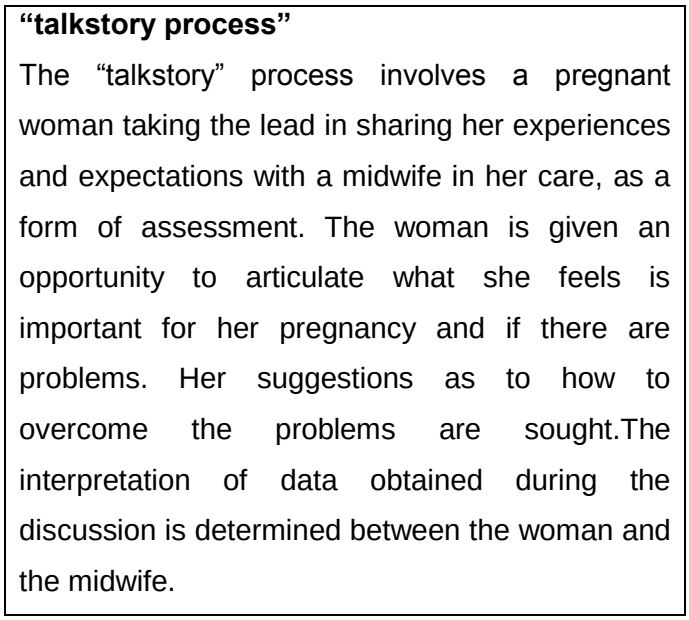

Figure 6.9: The "Talkstory" Process

The success of the “talkstory” approach

The “talkstory” approach, as illustrated in Figure 6.10, served as an ideal way of assessing women psychosocially. It offers an opportunity to provide the woman with relevant health information and to validate myths or misconceptions about childbirth that the woman might be having, while also addressing her expectations. This is a type of psychosocial assessment and care that is women-centered, through placing an emphasis on a woman’s own beliefs, offering her autonomy and a right to informed choice (Poat, McElligott and Fleming 2003).



Figure 6.10: Outcomes Achieved through the “Talkstory Process”

Much as a “talkstory” is an ideal approach during the initial contact of the woman and the midwife, and as such might promote communication between the two, it needs some time and requires a midwife who is skilled in listening and who has an ability to convey compassion, acceptance andencouragement to the woman. This approach might be a challenge in institutions experiencing the shortage of midwives.

6.3.7 Recommendations for Psychosocial Assessment and Psychosocial Care by Participants

The objective in this research was to establish a basis for the development of guidelines for psychosocial risk assessment and psychosocial support during antenatal care. The guidelines

were subsequently formulated based on responses from the midwives' survey, women survey, focus group discussions with midwives, focus group discussions with pregnant women and in-depth interviews with midwifery experts.

6.3.7.1 **Midwifery education and curriculum**

Both the midwifery experts and the midwives emphasized the importance of strengthening psychosocial care within midwifery education. The respondents' main focus was a holistic approach in midwifery care as reflected in Figure 6.11.

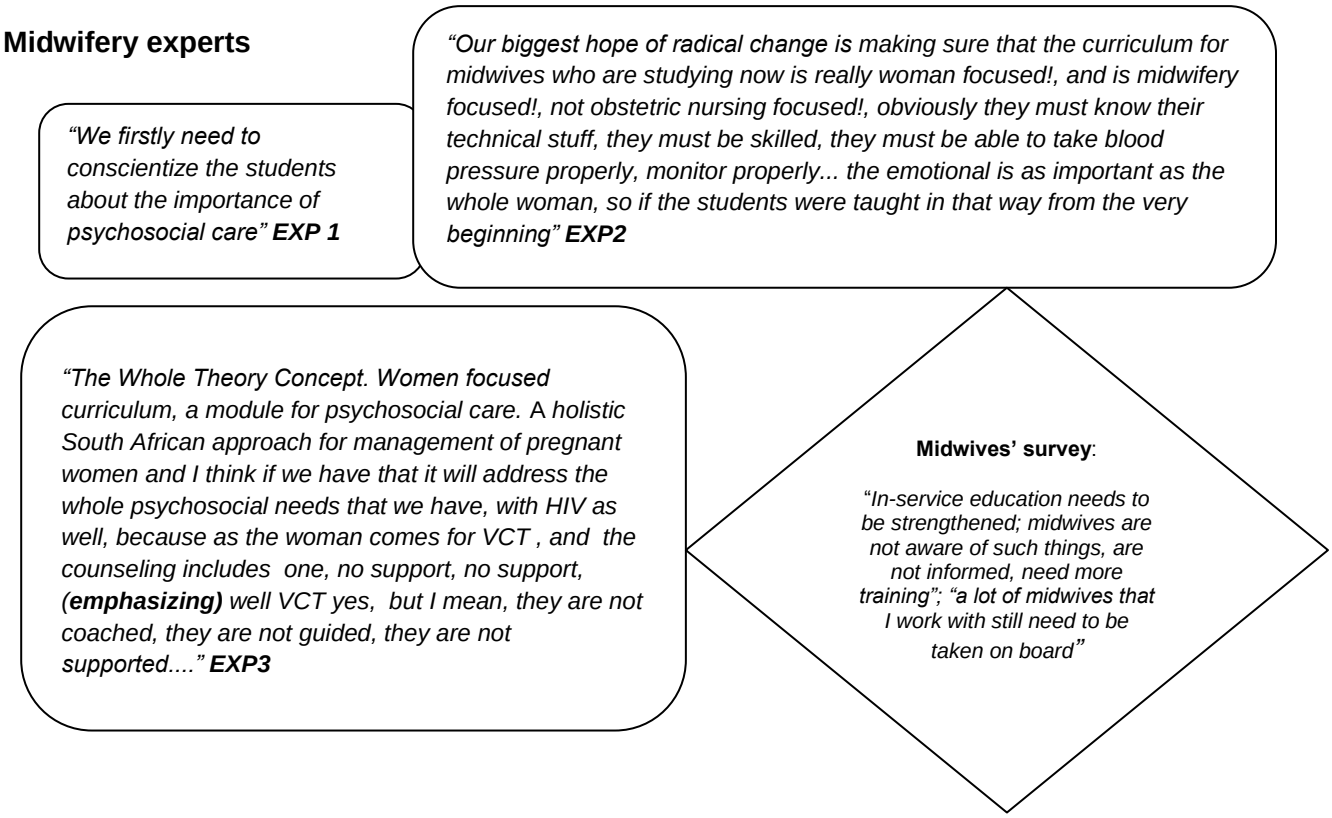

Figure 6.11: Participants' Recommendations for Midwifery Curriculum and Education (EXP= expert)

6.3.7.2 **Practice guidelines for psychosocial care**

Regarding guidelines for practice, the focus group discussions with midwives revealed a need for an antenatal card or a tool designed to guide them in assessing women psychosocially, which was also expressed in responses from the midwives' survey, as reflected in Figure 6.12. A midwife should be specifically allocated to assess women psychosocially, which will also

need more time. Furthermore, women's partners should be involved in supporting them in order to assist in managing women psychosocially. Women felt the need to be attended to emotionally and socially before the baby's condition is assessed. They further suggested a social worker to assist in addressing their psychosocial problems.

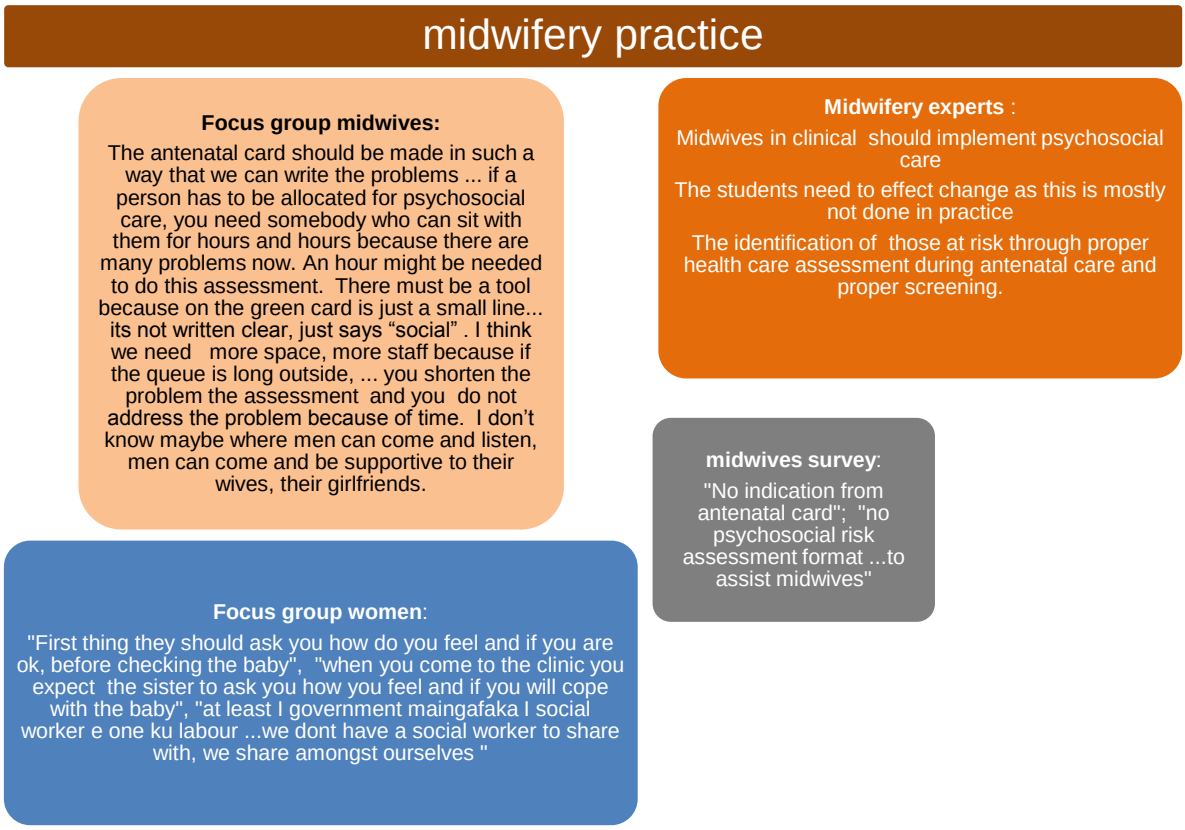

Figure 6.12: Clinical Guidelines for Psychosocial Care

6.3.7.3 Perceptions regarding psychosocial research

Midwifery experts, midwives in focus group discussions and pregnant women in focus group discussions shared their viewpoints regarding psychosocial care research as presented in Figure 6.13.

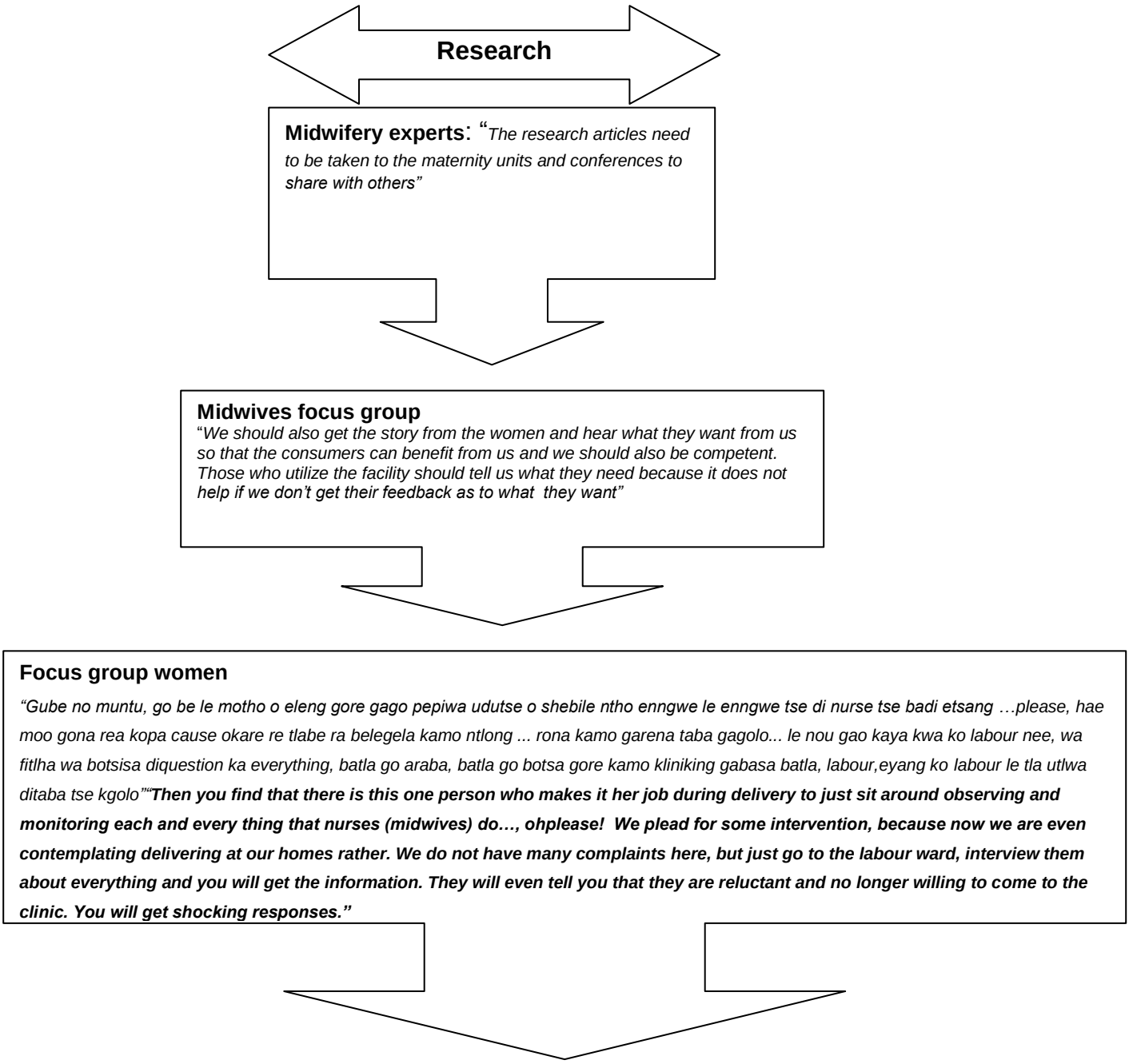

Figure 6.13: Research on Psychosocial Care

Midwifery experts focused on the dissemination of research findings whereas midwives in clinical practice recommend the evaluation of the service offered by midwives by the consumers. Assessing the quality of care from the women's perspective is supported by the notion that quality lies in the eye of the beholder, and this will strongly influence acceptance

and sustained utilization, compliance and the outcome of care (Fawole et al, 2008). Pregnant women in this study suggested that someone should be allocated to the labour unit to observe everything that midwives do to women, and ask women about their experiences of birth.

The women's main concern was around the labour ward more than the antenatal clinic. As stated by most respondents "*the type of care in the labour wardwill drive us to deliver at home rather than at the clinic"*. Both the midwives' and women's recommendation for feedback from consumers is fundamental to antenatal care, as it will provide the midwives and other health care providers with information regarding the antenatal care needs and the expectations of women.

Psychosocial research was identified as an important factor by midwifery experts, midwives in focus group discussions and women within this study. Austin, Priest and Sullivan (2008), in a Cochrane review editorial evaluated the effects of antenatal psychosocial assessment on mental morbidity of women during pregnancy and the first postnatal year, compared to routine antenatal care. The focus of the review was on the various psychosocial assessment tools and methods of application. The authors' assumptions were based on the hypothesis that "antenatal psychosocial assessment and early intervention contribute to reduced mental health morbidity and mortality and still need to be proven".

The conclusion of this Cochrane review was that much as psychosocial assessment increases the clinician's awareness of psychosocial risks, the reviewed studies did not provide sufficient evidence that routine antenatal care reduces morbidity and mortality. They recommended further studies with high sample sizes and with statistical power to explore the impact of psychosocial care on morbidity and mortality. Wilson, Reid, Midmer, Biringer, Carroll and Stewart(1996) and Rondo et al (2003) also recommended research to determine whether the detection of psychosocial risks leads to interventions that minimize postpartum psychosis or depression.

6.3.7.4 **Communication**

Communication as a major theme was raised by both midwives and women as in Figure 6.14. Midwives' perspective on communication within this study is that difficulty in communicating with pregnant women occurs due to language barriers, foreigners who need interpreters, women with speech and hearing disabilities, women who communicate through sign language in which the midwives are not competent, and those who are illiterate and cannot benefit from

health information on posters and charts. Women, on the other hand, related lack of communication to the attitude of midwives who were perceived as being unfriendly and unapproachable.

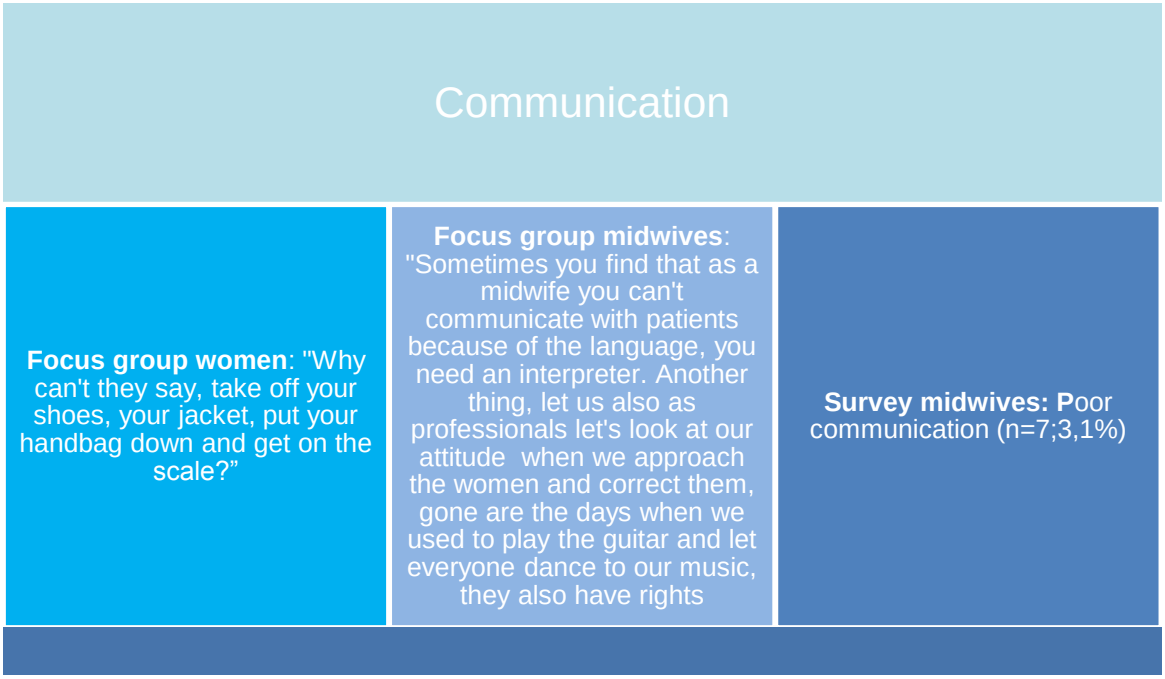

Figure 6.14: Participant's Responses Regarding Communication

Studies on women's satisfaction or expectations of antenatal care has shown that their dissatisfaction tends to be centred on poor communication and lack of information, Reid et al(1989); Clement et al,(1996); Mathibe-Neke (2008).Lack of communication between midwives and women often results in uncertainty. Mishel, 1981; 1990; 1997 as also cited by Handley (2006), describe uncertainty as a complex cognitive stressor that occurs when events are ambiguous and a person is unable to predict outcomes because sufficient cues are lacking.

Uncertainty is fundamental to both anxiety and depression, as the woman is unable to get meaning out of her pregnancy because the context of care is not structured to provide adequate cues. All pregnant women in the focus group discussions wished to be provided with as much information as possible about pregnancy and childbirth.

Communication emerged as a major theme within antenatal care during the focus group discussions held with pregnant women and midwivesas discussed under 5.3.2.5and Table 5.3.

Communication also came up as a major theme from the researcher's phenomenological study (Mathibe-Neke, 2008), which explored the expectations of pregnant women regarding antenatal care. In their responses, participants expected an established interaction with the caregiver through verbal, non-verbal and written communication.

According to Bick (2010), communication is a fundamental part of our daily lives, a high priority intervention to reduce maternal mortality and morbidity, but a poorly-rated element of maternity care. WHO (2008) emphasized the importance of communication between midwives and women during antenatal care as part of an initiative for its new antenatal care model.

The value of non-verbal and verbal communication during antenatal care cannot be overlooked as it plays a significant role in both physical and psychosocial care.

Non-verbal communication

Non-verbal communication is as crucial as verbal communication with regard to psychosocial care, as it conveys emotions, attitudes and feelings. Non-verbal communication can be achieved through the midwife creating a relaxed atmosphere of trust and speaking in the language that the woman understands and feels comfortable with. If not displayed properly it might contradict the spoken words. Ross and Deverell(2010) classifynon-verbal communication as proxemics, kinesics and paralanguage.

Proxemics or proximity refers to a conversational distance and an intrusion distance. Conversational distance, within the context of this study, can be applied to a distance created by a midwife between herself and a pregnant woman during antenatal care. If this distance is too wide it can be perceived as aloofness and coldness by the pregnant woman. An intrusion space should also be taken into consideration by being able to maintain the space and also to allow an opportunity for intrusion by other women, as otherwise important cues could be missed if a woman who intrudes is ignored.

Kinesics refers to body movements like facial expressions, which express emotions and degree of responsiveness. Smiling, as part of kinesics, mostly indicates a positive effect or liking. However this might depend on a cultural context; for example among Japanese, smiling could be perceived as a sign of embarrassment. Within the South African setting, smiling signifies embracing and acknowledging someone. Paralanguage refers to non-verbal communication through speech or voice, for example silence. Silence in some context might

imply interest and respect, whereas in others, specifically within the South African contextamongst most African cultures, it might be perceived as a negative emotional reaction, like a woman in this study who expressed herself saying "*she just listened, but did not say anything".* Midwives should achieve skill competency in communication as recommended by Bick (2010).

6.4 SUMMARY OF THE DISCUSSION OF THE STUDY

The study was of reasonable similar sample size for both quantitative and qualitative data. For example quantitative data were obtained from the total population i.e. SANC documents and the midwifery education records for the three nursing colleges in Gauteng province. Qualitative data were justified through within and across-group saturation.

The discussion reflects on the overall **goals** of the study which were: to have a personal, social, institutional and organizational impact; to understand the phenomenon of psychosocial care during pregnancy; to add to the knowledge base; and overall **objectives** of the study, that is to explore, explain, describe the phenomenon and influence clinical practice. The three main areas of focus in the discussion are the midwifery regulations and curriculum, midwifery education and midwifery clinical practice.

6.4.1 Midwifery Regulation

The SANC curriculum and midwifery regulations, at policy-making level emphasize holistic care in midwifery. The importance of holistic care was further raised by the responses from midwives' survey, midwives focus group discussions and experts' interviews. The Gauteng Nursing College's curriculum and learning guides also refer to a holistic approach to midwifery care as adopted from the SANC regulations.

Holistic health is multidimensional, characterized by an assessment of all determinants of health, and considering each patient or client as a whole person. A holistic approach to nursing care is based on ancient beliefs that the spirit is as legitimate a focus for nursing care as the body (Brooker et al, 2007).

The focus of holism on health is preventative and a belief in the body's own healing process, which can be achieved through physical, social, psychological care and the provision of health information. From a midwifery perspective, if a midwife believes that pregnant women are responsible for their own health care, she will engage with them in managing their

pregnancies. The main aim for a holistic approach is to achieve an optimum level of wellbeing, which is desirable for managing a pregnant woman. In holism, a health care provider is a facilitator and teacher, with an additional ability to assess and interpret symptoms that are deviant from normal health.This is in keeping with the focus of this study which is “psychosocial risk assessment and support” during antenatal care.

Holistic care is reflected as a key concept within the review of the South African Nursing Council (SANC) regulations and the midwifery curriculum which forms the basis for midwifery education and as such, midwifery Practice. The implication for SANC’s choice of holism as a philosophy, is to direct nurses and midwives to apply a holistic approach that looks at how the woman’s parts work together, rather than looking at each part in isolation. The focus should be on the whole organism or whole system. It is an approach that incorporates the interrelationships between all aspects of bodily functions and psychosocial functions. Holism, as such, emphasizes the importance of understanding a person’s whole being, rather than breaking down, studying or treating only the component parts.

6.4.2 **Midwifery Education**

The documents reviewed pertaining to midwifery education were; the midwifery curriculum, tests and examinations, midwifery learning guides, clinical formative and summative tools and the midwifery register. The review was based on the psychosocial care content that was covered theoretically and clinically over the four year review for documents from the three colleges.

The analysis of each regulation was achieved through counting all the objectives and classifying them under each of the four variables, viz. physical, social, psychological and collaboration/referral. The last three variables were put together as psychosocial care, and a percentage was calculated based on the number of objectives versus the total in the regulation. Regulation 425 pertains to the content to be covered for midwifery education and Regulation 2598 outlines the Scope of Practice for midwives, which is clinically based.

Figure 6.15 illustrates a comparison between the SANC requirementsfor psychosocial care as reflected in the regulations versus what is actually implemented in midwifery education. The general finding reflected a limitation in the facilitation of psychosocial care.

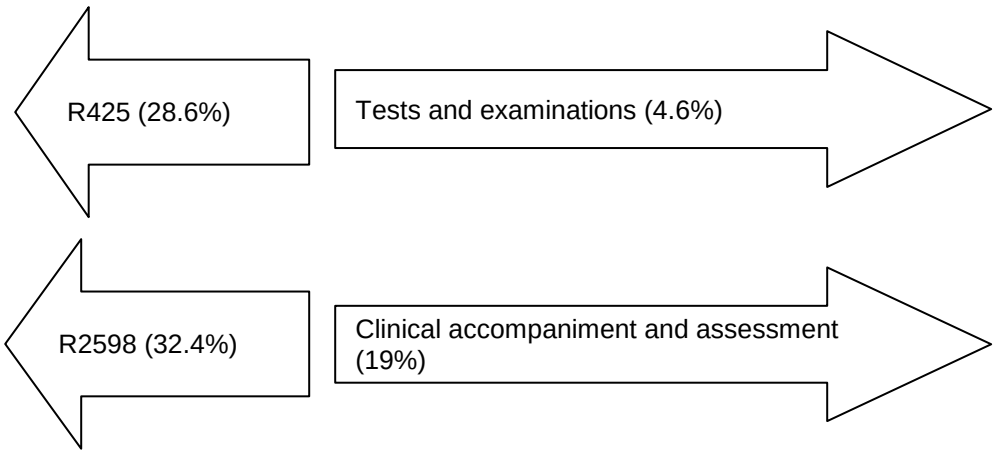

Figure 6.15: Psychosocial Content in Midwifery Regulation versus Midwifery Education

There is a significant difference in the quantity of the theoretical and clinical facilitation of midwifery students related to psychosocial care compared to what Regulation 425 and Regulation 2598 recommend. However, Regulation 2598 has the highest frequency of psychosocial objectives, which signifies the importance of implementing psychosocial care in midwifery clinical practice.This limitation has been identified in both the MNS 100 and MNS 200 courses.

The three colleges' curriculum and learning guides are focused on the physical, social, cultural and psychological factors affecting the womanwhich is an ideal foundation for facilitating students in psychosocial care. What is taught to students in MNS 200, which pertains to psychosocial care and is reflected in the colleges' learning guides, is teenage pregnancy, "postpartum blues", puerperal psychosis and depression, which overall is not adequate to provide holistic midwifery care.

The syllabus for MNS 100 does not address any social or psychological factors except for issues such as unemployment, which, once identified are taken to a further level to be managed. A factor that could be contributing to the lack of psychosocial care content, specifically in MNS 100, is the fact that the course is considered to cover normal or low risk pregnancy at this level. The syllabus needs to be restructured to include psychosocial factors like the woman's emotions, support system and other factors reflected in the psychosocial risk assessment tool, as well as the psychosocial resources available to support women. The midwifery clinical register should also include outcomes that are psychosocial.

The deficiency in addressing psychosocial care in midwifery education was also elicited from the responses of focus group discussions with midwives, and an 83% response from the survey conducted with midwives at a South African Midwifery Congress.

6.4.3 **Clinical Practice**

At the clinical practice level there were similarities in the findings of the midwives and the women, as they both highlighted the importance of psychosocial care during pregnancy and the fact that it is addressed to a minimal level. The conclusion is based on the findings of the focus group discussions with pregnant women, midwives, expert interviews and midwives' survey, which were discussed in chapter four and chapter five respectively.

The antenatal card, which is used to record the woman's progress of pregnancy during antenatal care, reflects broad concepts, for example social, obstetric, medical, surgical and family history. There is nothing regarding the woman's psychological wellbeing and the social aspect is not clearly elucidated as to which factors to assess and manage.

The Gauteng Antenatal Care Policy does not include the woman's social health in its objectives. Pregnancy isonly viewed from a physical and a mental perspective.On the other hand,the Guidelines for Maternity Care in South Africa (2007), as stipulated in a manual for clinics, community health centers and district hospitals, highlight the importance of assessing and managing a woman's physical, social and psychological wellbeing during pregnancy.

The objective of applying critical theory to this study was to empower midwives and pregnant women by recommending a change in antenatal care by incorporating psychosocial care, based on the findings and results of the study. The main focus was on the Regulations framing midwifery practice, the context in which midwifery learning takes place, and the structure and system of clinical antenatal care as provided in Gauteng Province.

Based on the findings of this study**,** no matter how much theory is given to students in class, they seem to be missing out on knowledge that should be acquired in clinical practice. To address psychosocial care in clinical practice, a bio-psychosocial midwifery skill model, as a form of a guideline, has been presented in Figure 6.16as adopted from Hall (1997).

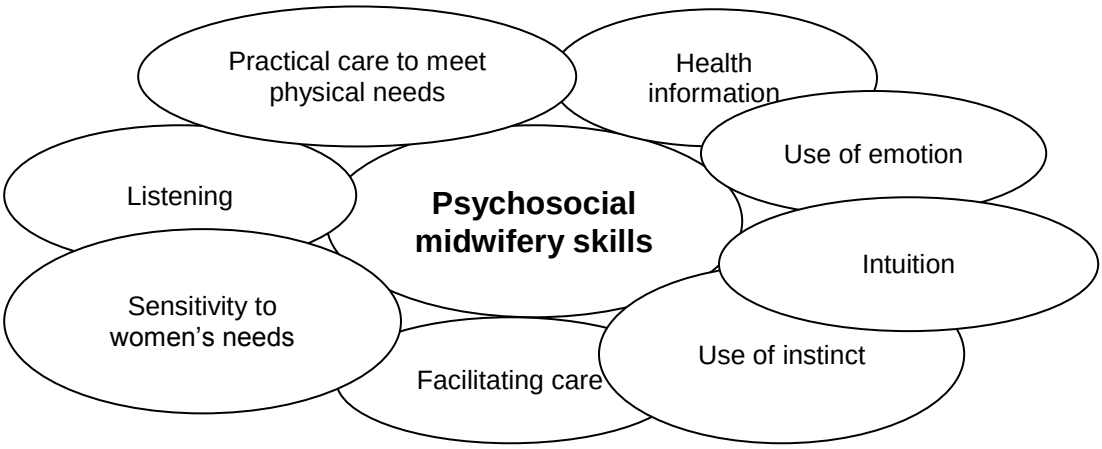

Figure 6.16: Midwifery Skills to Enhance Psychosocial Care

6.5 CONCLUSION

The general results of this study suggest that:

- The inclusion of psychosocial care is regulated at the SANC level.
- A gap exists between midwifery regulation, curriculum, learning guides and the theoretical and clinical facilitation of students, impacting on the clinical implementation of psychosocial care.
- Depressive and anxiety disorders and other psychosocial issuesare common in pregnancy and may also be associated with negative experiences during antenatal care.
- Midwives acknowledge the need for psychosocial care, but are not adequately equipped to implement it.

The above findings represent a call to the nursing colleges to close this gap by incorporating psychosocial care into the content that is taught (as recommended by SANC), to enable midwivesat the clinical level to empower women physically and psychosocially in order for them to be able to overcome barriers to safe motherhood.The emphasis is on providing information in order for women to make informed choices.

CHAPTER 7

7. PILOT STUDY ON PSYCHOSOCIAL RISK ASSESSMENT AND PSYCHOSOCIAL SUPPORT BY MIDWIVES IN THE ANTENATAL CLINIC

Chapter seven discusses findings of the pilot study that was conducted in two antenatal clinics of three Health Care Centers in Gauteng Province. The introduction and background are presented first, followed by the methodology applied, data analysis and finally a discussion of the findings.

7.1 INTRODUCTION AND BACKGROUND

A screening tool was developed in response to the findings from the midwives' focus group discussions at the three clinics, the responses from experts' interviews, the cross-sectional survey results from midwives, the responses of self administered questionnaires for pregnant women, and the information obtained through the review of the antenatal recordsused by women during antenatal care. Responses from focus group discussions with midwives and indepth interviews with midwifery experts further recommended that a tool for psychoscial care during pregnancy should be developed and implemented.

The general response from three hundred (300) questionnaires administered to pregnant women as presented in Table 4.12 indicated that 184(61.3%) experienced one or more stressful life events during the current pregnancy. Amongst those who experienced stressful life events, 72 (24%) experienced two events and 44 (14%) experienced three or more.

The midwives' survey revealed that numerous psychological and social problems were encountered by midwives in clinical practice, while teenage pregnancy, HIV/AIDS and poverty were the most frequent social factors recorded by midwives on the antenatal cards. The frequency of social factors ranged from one to three social problems for each of the 300 women whose antenatal cards were reviewed. The results from the survey indicated that psychosocial problems commonly exist during pregnancy. All of the above findings justified the importance of the development of a psychosocial screening toolto be used during antenatal care.

7.1.1 **Midwives' Focus Group Discussions**

The findings from the focus group discussions with midwives indicated a need for psychosocial assessment guidelines and a record as described under qualitative findings, chapter 5, subsection 5.3.2.4.

7.1.2 **Psychosocial Risk Assessment Guidelines**

The following comment was made by a midwifery expert regarding a psychosocial assessment guideline during in-depth interviews:

"There are several social kind of bits of history taken but there is nothing specific, you know, possibly if it was included in the green card, you know some more queries or questions, given the opportunity for that"

According to Klier et al (2008), earlier research has identified a number of psychosocial risk factors including low socioeconomic status, problems in marital relationships, stressful life events or absence of social support that often lead to postpartum depression. This further highlights the importance of the determination of psychosocial risks during pregnancy.

The American College of Obstetrics and Gynecologists has also published a recommendation to include assessment of psychosocial risk factors at each trimester of pregnancy as part of routine prenatal care. Screening should include assessment of barriers to care, unstable housing, unintended pregnancy, nutrition, communication barriers, substance use, depression, safety, intimate partner violence and stress (Klier, Rosenblum, Zeller, Steinhardt, Bergemann and Muzik, 2008).

The Guidelines for Maternity care in South Africa (2007) recommend that in preparing a woman for childbirth, consideration should be given to mental health, family, social and economic issues. The variables included in the checklist for this pilot study were mainly selected from the responses of the women to the self-administered questionnaire, which revealed that a majority of women experienced psychosocial risks at some point during pregnancy.

Risk screening, according to WHO (1998), involves using a list of risk factors and some form of scoring system to classify pregnant women into specific risk categories, typically 'high risk' or 'low risk', using cut off points or thresholds. The focus of this study is on psychosocial risk

screening in order to detect early problems and symptoms and to anticipate and prepare for any psychosocial complications.

7.2 THE AIM AND PURPOSE OF THE PILOT STUDY

The general purpose of the pilot study was to to raise the midwives' (those who took part in the study) awareness of psychosocial care, to improve the quality of psychosocial services and to fill the gap that has existed in routine antenatal care.

The pilot study aimed to obtain answers to the following questions:

- What were the midwives'perceived or observed knowledge and skill in implementing the psychosocial assessment tool, comfort with the tool and commitment to its use in clinical practice?
- In the midwives' opinion, to what extent did the use of the tool enhance antenatal psychosocial assessment and care?
- How has piloting the tool impacted on the health status of pregnant women?
- What barriers were encountered by midwives in implementing the tool?
- Is there possible value in integrating the tool into routine antenatal care?

7.3 METHODS

A cross-sectional survey was conducted inpiloting the formulated guidelines.

7.3.1 Participants

The total population was thirteen (13) midwives working in the antenatal clinics of the health care centres that participated in the study and the women who attended antenatal care at those centres. The distribution of midwives was three from the first clinic (**G1**), four from the second clinic (**G2**) and six from the third clinic (**G3**). The clinics were coded as G1, G2 and G3 during the presentation of qualitative findings in chapter five.

7.3.2 Procedure and Process

Aquestionnaire, in the form of a card, was used as a screening tool to for psychosocial assessment and support (Appendix R).One hundred and fifty questionnaires were distributed to each of the three clinics by the researcher.

A three month period was assigned for the pilot study to accommodate at least two follow up visits for women whose appointments for antenatal clinic are usually at four weekly intervals.

The questionnaire contained twenty closed-ended questions in the form of a checklist, to be administered by midwives during the woman's booking visit, and to be reviewed during subsequent visits to ensure continuity of care. The items included in the questionnaire were based on the women's responses to the self-administered questionnaire (Appendix S).The questionnaire was attached to the antenatal card that is used for routine antenatal care by midwives.

The questionnaire had a covering letter for clarifying the process, and was designed to assess a variety of psychosocial risk factors related to the woman's emotional status, an indication of whether the pregnancy was intended and wanted, the woman's relationship with the father of the baby, the support system available for the woman,financial resources, any indication of abuse, substance abuse, safety at home and at work, and anxiety and stress experienced during the current pregnancy.

A follow up plan for psychosocial care was included as part of the questionnaire, as adapted with permission from theAntenatal Psychosocial Health Assessment (ALPHA) Group, April(2005) (Appendix H).The care plan includedsupportive counseling by the midwife assessing pregnant women psychosocially, prenatal education which would assist a woman in understanding her condition or situation, information about the services that she would receive as part of antenatal care, and endeavours to reduce anxiety, especially for women experiencing their first pregnancy. The care plan further included referral to resources such as smoking cessation and addiction programs, family therapy, a psychologist, social worker or women's organizations. All referrals aimed to address psychosocial risks identified during assessment by the midwife.

A Likert scale-based evaluation was used to assess the validity and reliability of the questionnaire and usability by midwives (Appendix V). Factors affecting its use were assessed in order to evaluate the effectiveness of the psychosocial assessment questionnaire. The form was comprised of closed-ended questions and an additional space was provided for further comments by participants. Agreement to participate in the pilot study was considered a form of consent. The midwives who agreed to pilot the questionnaire were given an evaluation tool to complete at the end of the process.

The Clinic Managers were fully briefedthrough a presentation and an information sheet on all aspects of the research, and the researcher ensured that the managers understood the methodology of using the questionnaire in order to explain it to the midwives in the clinic.

The researcher visited the clinics twice during the pilot period to monitor progress and to address any implementation problems encountered by participants. One clinic delayed commencing with the study and suggested to the researcher that she should rather conduct the pilot as the clinic did not have adequate staff and time. This indicated lack of understanding of the purpose of the tool and its potential to enhance antenatal and postnatal care.

The implementation of the questionnaire and feedback from the clinics were completed within six months, three months beyond the planned period of piloting, which was an advantage for continuity of care if the tool was properly implemented. One clinic eventually declined participation and submitted the reasons for withdrawal as no clarity or in-service training regarding the use of the tool and shortage of staff.

In this case, the clinic manager had taken over from the previous manager and was probably not well informed about the tool. The unused one hundred and fifty cards were given to another clinic that had requested more cards initially and the clinic was more than willing to use them beyond the pilot study phase.

Another reason for failure to pilot the tool by the clinic which withdrew participation was that women were reported by midwives to have been reluctant to be interviewed on the extra questions because they were in a hurry to go home, which is contrary to the researcher's informal observation and engagement with women. The factors that could have contributed to women being reluctant to be assessed psychosocially are the waiting time estimated at three hours for women in this specific clinic which was revealed from focus group discussions with women in this study.

The attitude of midwives and the lack of communication that was reported during focus group discussions with women could have possibly led to some women being reluctant to be assessed psychosocially by use of the tool. The results of a study by Menon et al (2010) on the perception of Zambian women attending community antenatal clinics confirmed that women might feel intimidated by the antenatal care process, which may impair communication as women are reluctant to disclose their problems.

7.3.3 Validity

Face validity and applicability were addressed during the development of the tool through the review of the tool by the researcher's supervisors, ensuring that the variables within the tool represent the domains that were to be assessed.

7.3.4 Data Analysis

Descriptive analysis was used for the Likert scale responses. Further responses from participants were thematically analyzed.

7.4 RESULTS

Ten evaluation sheets (100%), were received from two clinics that participated in the study. The distributed psychosocial assessment tools (n=300) were reported to have all being used to assess women during first antenatal visits.The results are discussed under the pilot study questions with reference to Table 7.1 that illustrate a summary of responses from clinic 2 (Figure 7.1) and clinic 3(Figure 7.2).

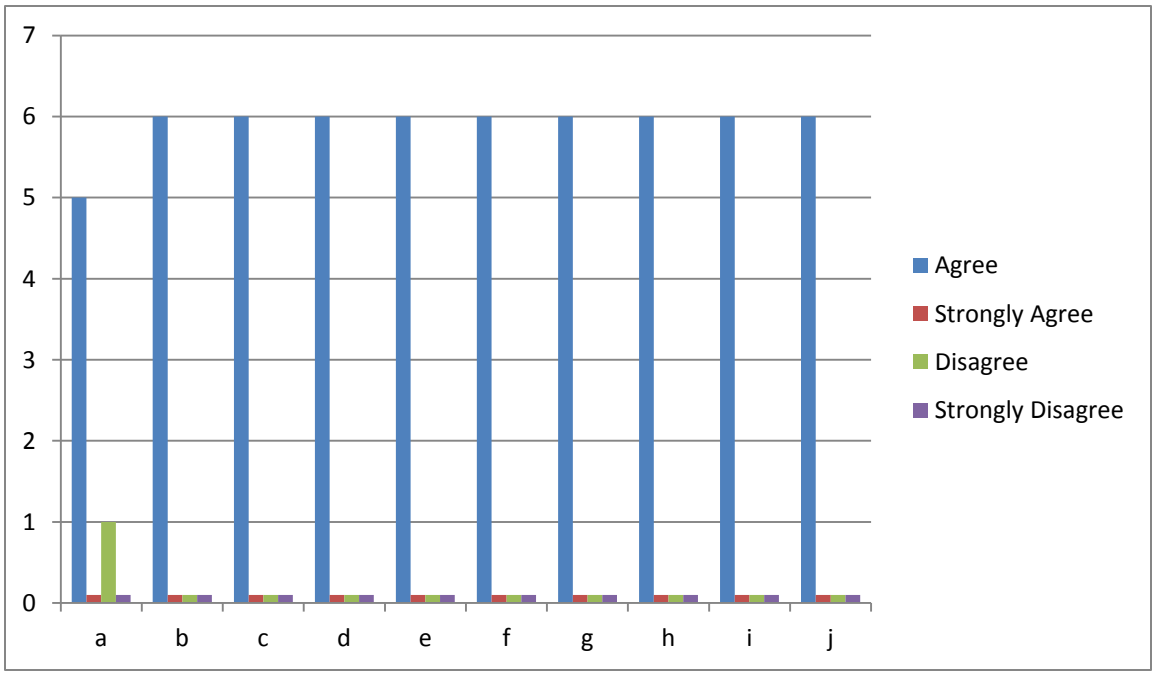

Figure 7.1: The Understanding and Use of the Pilot Tool by Midwives in Clinic 2:G2(*n*= 6)

Categories as applied to both clinic 2 and clinic 3 (Figure 7.1 and Figure 7.2)

a. I understood how to use the antenatal psychosocial assessment tool
b. I am comfortable with performing antenatal psychosocial assessment
c. I commit to and support the use of the antenatal psychosocial assessment tool
d. More psychosocial problems were identified by using this tool
e. The number of referrals increased due to the use of this tool
f. This assessment improved the wellbeing of pregnant women
g. The quality of communication between you and pregnant women improved with the use of this tool
h. In your opinion, are women happy to be assessed using this tool?
i. Barriers encountered in the implementation of psychosocial assessment and psychosocial care
j. The assessment should form part of routine antenatal care

Participants from clinic 2(*n*=6) indicated an understanding of the tool, except for one respondent. The general responses were positive regarding the use of the tool. A variety of responses and a very different pattern was obtained from clinic 3 (*n*=4), with one participant disagreeing that the number of psychosocial referrals increased by using the tool. Half of the participants did not encounter any barriers to the implementation of the tool, and one respondent was not keen to use the tool as a component of routine antenatal care.

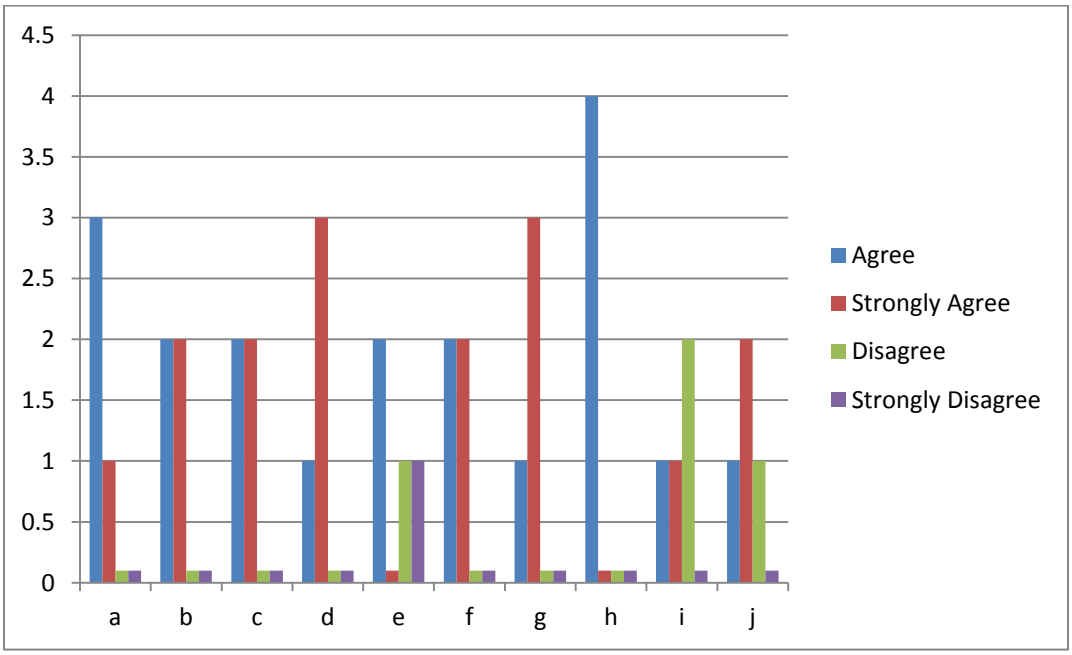

Figure 7.2: The Understanding and Use of the Pilot Tool by Midwives in Clinic 3:G3 (*n*=4)

Table 7.1 presents thematic analysis of midwives' responses regarding the use of the tool.

Table 7.1: Thematic analysis regarding use of the pilot tool

Factor	Likert scale responses				Frequency
Understanding	A **8**	SA **1**	D **1**	SD 0	9agreed and 1 disagreed
Implementation	A **8**	SA **2**	D 0	SD 0	10agreed
Support the use of tool	A **8**	SA **2**	D 0	SD 0	10agreed
More psychosocial problems identified	A **7**	SA **3**	D 0	SD 0	10 agreed
Referrals increased	A **8**	SA 0	D **1**	SD **1**	8agreed2 disagreed.
Improved wellbeing	A **8**	SA **2**	D 0	SD 0	10agreed
Enhanced communication	A **7**	SA **3**	D 0	SD 0	10agreed
Women's responses	A **10**	SA 0	D 0	SD 0	10agreed
Barriers	A **7**	SA **1**	D **2**	SD 0	8agreed 2 disagreed.
Routine antenatal care	A **7**	SA **2**	D **1**	SD 0	9 agreed 1 disagreed

Key: A=Agree; SA = Strongly agree; D = Disagree; S=Strongly disagree

7.5 DISCUSSION OF RESULTS

The following discussion addresses the study questions and refers to Figure 7.1, Figure 7.2 and Table 7.1.

7.5.1 The Midwife's Understanding and Skill in Implementing the Tool

As reflected in Table 7.1 the majority of participants (*n*=9), indicated that they understood and were able to use the tool to assess women during antenatal visits. All participants declared comfort with and commitment to using the tool. Literature indicates that the introduction of such

an initiative for psychosocial assessment as a new concept is likely to be supported by the midwives (Willinck etal, 2000).

7.5.2 The Extent to which the Tool Enhanced Antenatal Psychosocial Assessment and Care

All participants agreed that the use of the tool led to the identification of more psychosocial problems, improved communication between the midwife and women, a marked increased the number of referrals, (*n*=8), and improved general wellbeing of the pregnant woman.

As a measure to promote psychosocial risk assessment,anew approach to psychosocial risk assessment during pregnancy (ANEW) project was initiated to provide an alternative way to psychological risk screening in pregnancy (Gunn et al, 2006).A training program in advanced communication skills and assessment of common psychosocial issues arround childbirth was offered to midwives and doctors at the Mercy Hospital for Women in Australia, with the aim of improving the identification and support of their psychosocial needs in pregnancy. The outcome of the program was improved competence of health care professionals in identifying and caring for women with psychosocial problems. This was also revealed by participants in this pilot study.

A randomized controlled trial on the effectiveness of the Antenatal Psychosocial Health Assessment (ALPHA) Tool in the detection of psychosocial risk factors for postpartum depression (Blackmore et al,2006), revealed that the intervention group included a significantly higher proportion of women with antenatal psychosocial risk factors for post partum depression(36% versus 26%) and a significantly higher number of risk factors per woman compared with the control group (mean 2.1 versus 1.8)(z= -1.96, p=0.05).

The results led to a conclusion that the ALPHA tool, which was developed from a systematic literature review, provided a systematic means of eliciting antenatal psychosocial risk factors for postpartum depression and could be used for assessing sensitive issues. A further recommendation based on this study was the administration of a simple standardized measure to assess psychosocial risk factors during routine antenatal care, which was the case with this pilot study. An added benefit of using the ALPHA tool was the enhanced provider-patient relationship, as reported by both health care providers and women

Several authors, over a time-span of fifteen years, concluded their studies by recommending routine psychosocial antenatal assessment and care, screening should be performed

regularly,and the patient's prenatal history should be well documented (Lapp, 2000). Women and providers have recommended that the assessment should be part of routine prenatal care for all women (Midmer, 2006). In another study that surveyed physicians, 77% indicated that an antenatal psychosocial risk assessment would be of some benefit, while only 15% indicated it would not be useful (June et al, 1994). Canals et al (2002), further suggested that a plan of support that includes psychological aspects, could have a positive effect on the general wellbeing of the mother and consequently on the baby.

7.5.3 The Response of Women regarding being psychosocially assessed

Almost all participants from the pilot study indicated that most of the three hundred women seemed happy when being assessed using the tool, although one participant highlighted that some women seemed reluctant to be assessed feeling that midwives are inquisitive.

A randomised controlled trial by Carroll and associates(2005), in examining the effectiveness of the Antenatal Psychosocial Health Assessment (ALPHA) form in detecting psychosocial risk factors in pregnant women, revealed that 72.7% of the women in the ALPHA group showed interest in discussing issues. The study group was almost twice as likely to manifest psychosocial problems as compared to the controls, based on odds ratio of 1.8 and confidence interval 95% of 1.1-3.0; $\rho = 0.02$). Of the health care providers in the ALPHA group, 64% found the form easy to use and 86% would use it if it were recommended as standard practice.

Contrary to the perception by some of the pregnant women in one clinic that the assessment tool is invasive, as reflected within this response*"women were reluctant to be introduced to the tool, they felt it's being inquisitive"*, this was not the case with women who were assessed in the other clinic and with those who participated in the following studies on psychosocial risk assessment, as most expressed appreciation for the opportunity to discuss personal issues (Reid et al, 1998; McCourt and Pearce, 2000; Willinck et al, 2000; Carroll et al, 2005; Midmer, Bryanton and Brown, 2006; Edwards, Galletly, Semmler-Booth and Dekker, 2008).

7.5.4 The Potential for Integrating the Tool into Routine Antenatal Care

The majority of midwives (*n*=9, 90%) recommended that the tool could be used for routine antenatal care, furthermore that the tool could be modified, but did not indicate how.

"the tool is clear and easy to be communicated"

"It encourages pregnant women to communicate with professional nurses and becomes easy to refer patient to appropriate areas"

"the tool is well arranged, hope will be added on the new maternity records"
"I agree that it should be included in the antenatal card as it will enhance wellbeing"

Some preferred a shortened version of the assessment form:
"it might be shortened so that it can be easily included on the patient's green card"

Almost all midwives (*n*=9) in this pilot study recommended the routine use of this tool for antenatal care. The response is similar to the findings of a study conducted by Willinck et al (2000) in the Hume Region of North East Victoria, on psychosocial risk assessment during antenatal care, which revealed that midwives in the experimental group were more satisfied with the project than midwives in the control group. More than 57% of midwives in Willinck's study preferred the use of the risk assessment tool over the traditional antenatal assessment.

Willinck et al (2000) further recalled that domestic violence during pregnancy had been reported at 16% (Parker et al, 1993) and postnatal depression affecting 15-20% of women (Brown et al, 1994). Furthermore, much as these figures were higher than the incidence for gestational diabetes, placenta praevia, pre-eclampsia and other medical conditions, no commitment has been shown by health care providers to routine psychosocial screening.

7.5.5 The Barriers that were encountered in testing the Tool

The midwife respondents in the pilot study reported the following as barriers to the implementation of the tool:

Not being well orientated on the use of the form as indicated by one clinic that withdrew from the study.

Shortage of staffwas stated by 80% of the participants as a barrier to the implementation of the tool, "*the challenge that midwives are facing is shortage of staff";* "*the assessment tool should not form part of routine antenatal care because of shortage of staff".* Staff shortage is a widespread and chronic problem in the health care sector. The World Health Organization estimated a 4,3 million worldwide shortage of health personnel in 2006. As stated in Waldner (2008), a high level task team was established in 2008 as one of the outcomes of the Human Resources for Health Indabain Gauteng Province to address problems that contribute to staff shortages. This followed an indication by the then Head of the Health Department that Gauteng Province needed 7000 nurses to fill vacant posts.

The impact of the shortage of practicing midwives is a challenge to the implementation of psychosocial assessment and psychosocial care during childbirth, and this was previously raised as a major concern during focus group discussions with midwives.

Regardless of the shortage of staff posing an obstacle to assess women psychosocially, the midwife has a duty to her clients and a professional accountability to be competent, up to date with, and toimplement evidence based practice that will improve care for the woman. Furthermore, midwives should welcome the opportunity to contribute to research and thereby an opportunity to offer comprehensive midwifery care.

Another obstacle mentioned is the existing **Infrastructure**with reference to lack of, or inadequate physical structures to provide privacy during psychosocial assessment, based on the following response"*thechallenge is space for continuous individual assessment".*

Resistance from womenwas also mentioned as a barrier**,** participants indicated that*"women were reluctant to be introduced to the tool, they felt it's being inquisitive"* .This reaction from women may be related to several factors for example, that the purpose of the assessment was not adequately clarified to women, negative emotions such as anger which were reflected during focus group discussions with expectant women, feelings of powerlessness and injustice, a breakdown in the interpersonal relationship between midwives and women as women claimed to have mostly received insensitive care from midwives .

The findings of randomized controlled trials of a self reported and provider- administered psychosocial assessment form (Blackmore et al, 2006; Carroll et al, 2005 and Reid et al, 1998) established that women preferred a self-reported form of assessment which was less intrusive to write their experiences rather than discussing them with the midwife. This could be similar to this pilot study. To enhance women's responsiveness to psychosocial assessment, the antenatal service should meet the women's expectations of care, and protect their rights to dignity, privacy, autonomy, choice and decision making.

7.5.6 Further Comments by Midwives

The thematic analysis of further comments by participants led to the development of four themes which were: the identification of psychological risks, a will to support women, the consideration of the uniqueness of the expectant woman and the identification of postpartum complications as reflected in Table 7.2.

Table 7.2: Open-Ended Responses regarding the Use of the Tool

Themes	Responses Verbatim
Psychosocial risks	*"I have identified that most women have psychosocial problems during pregnancy and after delivery"*
Will to support	*"They need support and empowerment throughout the process"*
Identification of complications	"*The use of the tool will remind the healthcare worker about the psychosocial aspect to prevent postpartum problems*"
Uniqueness of the expectant woman	"*The primigravidas displayed fear of labour as they had no knowledge of what to expect"*

The comments from midwives showed their involvement and advocacy role in psychosocial care. The importance and the need for screening psychosocial risks during pregnancy has been recommended by several authors (Raynor, Sullivan and Oates, 2003; Hamid, Asif and Haider, 2008; Matthey, Phillips, White 2005; Blackmore et al, 2006; Midmer, Bryanton and Brown (2006), Klier et al, 2008).The findings of the pilot study showed that psychosocial wellbeing during antenatal care is important for both women and midwives, which was also indicated in the initial phase of this study.

Women should be acknowledged as individuals with different needs, values and preferences. Women who are pregnant for the first time should be given information, for example about the changes that occur during pregnancy, the danger signs, signs of labour and the birthing plan. Dragonas et al(1998), in their article on prenatal care, stated that a realistic examination of fears and psychological problems during pregnancy by social support personnel is necessary for the prevention of potential pregnancy complications. It seems ideal that psychosocial assessment and care be initiated at the first antenatal visit for it to be effective.

7.5.7 Possible Limitations

The pilot was a small-scale trial run which limits generalization to a larger population. This was compounded by the loss of information from participants (*n*=3) who withdrew from the study. The tool did not quantify psychosocial risks that were uncovered by midwives which might have contributed to a motivation to incorporate the tool into routine antenatal care.

Furthermore, while the set of questions asked by midwives appeared to be relevant and useful, there may well be other psychosocial issues that have not been explored in the research described in this thesis.

7.5.8 **Further Research**

A larger scale pilot of the tool that would also indicate the prevalent psychosocial problems and the resources required to address them. Another study could focus on the pregnancy outcomes following routine psychosocial assessment.

7.6 **CONCLUSION**

The implementation of psychosocial care served as a major purpose for this study. The findings from this pilot study are important in that they too suggest that pregnant women experience psychosocial problems. The implication of the findings appears to be that midwives are willing to incorporate the psychosocial assessment tool into routine antenatal care.

As a pilot study is nothing more than a potential precursor to a major study, there remains a need to test the tool on a larger sample which might elicit more factors that could hinder or help its implementation. The findings might also be used to advocate for the incorporation of the tool into routine antenatal care. While the use of this antenatal psychosocial pilot tool may increase the midwives' awareness of psychosocial risks and form a basis for further studies, a bigger sample size validation of the tool and statistical power are required to provide evidence that routine antenatal psychosocial assessment would also lead to improved outcomes for mother and/or child.

CHAPTER 8

8. CONCLUSIONS, LIMITATIONS, GUIDELINES AND RECOMMENDATIONS

8.1 INTRODUCTION

Chapter eight presents the study's conclusion, limitations, guidelines andrecommendations. The focus is on the aims and objectives of the study, the research questions, key concepts and specific major themes as generated from qualitative findings and the quantitative results. The intention of the discussion is to provide conclusions to the overall findings of the studyon particular themes and develop guidelines or recommendations for each theme. The focus of recommendations and guidelines is on midwifery regulation, midwifery education, clinical practice and research.

8.2 THE OVERALL FINDINGS OF THE STUDY

The overall aim and purpose of the study, as stated in 1.4.1 held hope that the results and findings of the study would provide evidence which could motivate interventions aimed at closing the gap between the routine assessment of physiological risk factors and the assessment of psychosocial risk factors during antenatal care. The study further aimed at formulating guidelines for psychosocial care based on the findings of the study.Once formally tested, such guidelines could be incorporated into national guidelines for best practice.

The objectives of the study were achieved as the researcher managed to establish and explain the extent of psychosocial risks in the clinics where the study was conducted; explored and described the following: the midwifery content designed to educate students regarding psychosocial assessment and psychosocial care for pregnant women;the awareness and knowledge of psychosocial risk assessment and psychosocial care by midwifery care providers during pregnancy,and the experiences and satisfaction of pregnant women regarding psychosocial care offered during antenatal visits.

Furthermore, the study managed to answer the quantitative and qualitative research questions stated in 1.7. The researcher's philosophical assumptions, values and beliefs of holistic and comprehensive antenatal care as stated under 1.4.4.1 were also validated.

The findings of the study affirmed the nursing theories applied in the study, those of Virginia Henderson's four constructs and Jean Watson's Theory of Human Caring which focuses on

the art and science of human caring. Henderson's constructs involve the sociological and the psychological aspects of health care, evidence of which was found in this study. Henderson's focus is on the holistic approach, emphasising the mind, social and spiritual aspects of a pregnancy.

Jean Watson's theory is based on humanitarian, metaphysical, spiritual-existential and phenomenological orientation that draws from Eastern philosophy (Watson, 1979; Fawcett, 2005). Her theory offers a way of conceptualising and maximising human-to-human interaction that is central to nursing, which forms a basis for establishinga therapeutic relationship and communication between the midwife and the woman. The promotion of a supportive environment to enhance nature's healing process by Florence Nightingale (Light,2011)and Abraham Maslow's Hierarchy of Human Needs (McLeod, 2007), which explains the progression of human needs, from basic physiological to self-actualisation, were also reflected in the findings of the study.

The four theorists or philosophers all hold a holistic viewpoint of health care which is in keeping with the guidelines of SANC as the midwifery regulating body, and the expectations of pregnant women as the consumers of midwifery care. Feminism also reflected within the study results as the midwives and women were involved in the construction of knowledge in the form of contributing to the development of guidelines that were piloted for psychosocial care.

The findings of this study, based on the responses of pregnant women and midwives, the reviewed antenatal cards (Table 4.3),interviews with midwifery experts, as well as supporting literature presented in chapter one,provided evidence that psychosocial problems do exist beyond the South African context. Although midwives (in both focus group discussions and the survey participants) seemed to understand and acknowledge the importance of psychosocial care (Table 4.14 and Table 5.1), their interest, abilities and competencies seemed to be directed towards foetal wellbeing over maternal wellbeing.This is evidenced through the system of antenatal care that is routinely offered to women, and as such, compromisespsychosocial wellbeingof pregnant woman. This situation is further compromised by the shortage of midwives, as also indicated in the midwives' responses.

The overall purpose of the study was therefore to address a pregnant woman's psychological status, to the benefit of her foetus and her own postnatal wellbeing.
The aim of the study was achieved by addressing the following objectives and processes:

8.2.1 Objective 1: To Establish the Existence of Psychosocial Risks during Pregnancy

The objective was to establishthe existence and extent of psychosocial risks experienced by women during pregnancy and as perceived by midwives in their care. The objective was explored quantitatively through the review of antenatal cards in which the women's antenatal care is recorded; the antenatal cards were reviewed for the assessment of midwives' recorded psychosocial risks and psychosocial care. A self-administered questionnaire was distributed to pregnant women at three antenatal clinics. A self-reported questionnaire was distributed to delegates at a midwifery congress in South Africa.

The midwives survey responses were established from a question that asked them to list the psychosocial risks/problems they encountered during the management of a pregnant woman (Appendix L, no.4).The existence of psychosocial risk was further qualitatively explored by conducting focus group discussions with midwives working in the antenatal clinics, and in-depth interviews with midwifery experts were also conducted. Psychosocial needs were established from women through focus group discussions.

Findings

There is an indication of psychosocial risks or problems from both quantitative and qualitative responses.The reviewed antenatal cards revealed the existence of social problems, and minimal psychological risks as recorded by midwives managing women antenatally.Psychosocial problems experienced by pregnant women were reflected by their response to questions on their emotional status during the current pregnancy, perceived lack of social support,experiences of family violence and of stressful life events (Appendix S). The midwives survey responses revealed a list of psychosocial risks they encountered from women during antenatal care, intrapartum and postpartum units, and their interventions to address them.

Focus group discussions with midwives revealed that they encountered psychosocial risks from women that they manage during antenatal care. Women further indicated their need for psychosocial support as part of routine antenatal care.

Conclusion

The fact that psychosocial risks exist was verified by all participants in the study,implying a need for assessing women psychosocially during antenatal care and offering them psychosocial support.

8.2.2 Objective 2: To Explore and Describe the Midwifery Content Designed to Educate Students regarding Psychosocial Assessment and Care of Pregnant Women

The objective was to explore the content designed to educate and facilitate student learning regarding psychosocial assessment and psychosocial care of women during pregnancy and childbirth. The objective was met through the review of the South African Nursing Council (SANC) midwifery regulations (R2598 of 1984, R2488 of 1990, R425 of 1985 and R387 of 1985, as amended), the review of the curriculum of the three Gauteng Nursing College's midwifery as approved by SANC, the midwifery learning guides, clinical tools used for midwifery education, tests and examinations written by students. Self-reported questionnaire responses from midwives and in-depth interviews were conducted with midwifery experts to establish their perception of psychosocial care content in midwifery education.The antenatal card carried by women as a record for antenatal care was also reviewed.

The Gauteng antenatal care policy (1997), the midwifery competencyregister and the Guidelines for Maternity care in South Africa (2008) were evaluated for psychosocial guidelines.

Findings

The SANC Regulations, the curriculum and learning guides display a broad approach to psychosocial care as the focus is on holistic care. Written tests, examinations, clinical tools implemented at the colleges address psychosocial care to a minimal level (Figure 6.4). The Gauteng antenatal care guideline policy, theGuidelines for Maternity care in South Africa (2007)and the midwifery competency register do not reflect psychosocial content in its guidelines or psychosocial criteria to be met during antenatal care. The antenatal card does not reflect guidelines on psychosocial care, as such midwives recorded what they perceived as relevant to be assessed.

Conclusion

Much as a holistic approach to midwifery care is reflected within the SANC Regulations and midwifery curriculum, it seems to be broadly stated, non-specific and non-directive inguiding midwifery educators regarding the extent of the inclusion of psychosocial carewithin the institution's curriculum. The researcher's conclusion is based on the outcome of the review of

midwifery education documents for the three Gauteng Province nursing colleges and the responses from in-depth interviews conducted with midwifery experts.

8.2.2.1 **Recommendations for midwifery regulation and midwifery curriculum**

The researcher recommends that the SANC regulations shouldbe designed in such a way that they clarify the amount and content of psychosocial care within the midwifery education curriculum, as the content to be covered by midwifery educators is based on the SANC regulations as a guideline for midwifery education. The researcher further proposes for SANC and the midwifery education institutions the following guidelines for curriculum design based on the study findings:

- The use of a dynamic model of curriculum development as a frame of reference for curriculum development. The dynamic model is flexible, involves deliberation by all stakeholders, considers situational analysis and is evidence-based to ensure that the proposed curriculum is relevant to address the health care needs of the society that the graduates will serve (De Villiers,2001).
- The concept of holism to be further clarified within the SANC midwifery regulations to provide a functional meaning for midwifery educators and midwives in clinical practice.
- The appropriate distribution of the psychosocial component in midwifery care, theory notional hours, clinical psychosocial hours and standards for clinical assessment tools.
- The inclusion of psychosocial assessment as a component for competency in the midwifery education register: Table 4.10 (REF.P95).
- The establishment of a link between midwifery education institutions, research and clinical practice to collaborate and coordinate the development of midwifery curriculum and protocols for midwifery practice that will include psychosocial care.
- Offering a “woman-centered care approach” curriculum.

8.2.2.2 **Curriculum design**

The curriculum forms a theoretical basis for clinical practice, which, if it addresses psychosocial care, will provide an expected outcome of the implementation of psychosocial care in clinical practice.The researcher’s proposal below covers astandardizedcurriculum that could be used by SANC and adapted and implemented by nursing colleges to enhance psychosocial care in midwifery education.

Table 8.1: Guideline for Curriculum Design

Curriculum component/ content	Outcomes	Notional hours	Theory facilitation	Practice facilitation	Assessed
Antenatal care 1. History taking (booking visit)	1. Determine existing and potential psychosocial risks (use of assessment tool) 2. Offer psychosocial support			▪ Student accompaniment ▪ Workbook ▪ Case study	▪ Written assessment ▪ Formative and summative clinical assessment
2. Subsequent antenatal visits	1.Takes account of continuous psychosocial assessment (psychological and emotional adjustment / changes) 2. Offer psychosocial support				
3. Intra-partum care					
4. Postpartum care					

8.2.2.3 **Midwifery education**

Although the South African Nursing Council curriculum and Regulations do not clearly outline or indicate the percentage of the content which should address psychosocial care in midwifery education, they put an emphasis on holistic care as a principle inmidwifery education and clinical care. The Guidelines for Maternity Care in South Africa (2007) also reflect a holistic approach to midwifery care. The psychosocial guidelines in the Gauteng Antenatal Care Policy (1997) for the management of pregnancy are very limited as explained in 6.3.3. The midwifery register is designed to ensure that the midwifery student in the basic midwifery program is competent by meeting set outcomes in clinical practice, measures criteria for physical care only, and no criteria are given for management of psychosocial care.

Basic midwifery education in South Africa is offered over two academic years. The first year of the midwifery course covers low risk pregnancy, labour, puerperium and the neonate,whereas the second year covers high risk pregnancy, labour, puerperium and the high risk neonate. The researcher is of the opinion that this arrangement of course content might lead midwifery

students to compartmentalize women into two separate entities, normal and abnormal pregnancy.

The chances are that the compartmentalization of women would extend from the classroom level to clinical practice. This approach, from the researcher's perspective as a midwifery lecturer, compromises psychosocial aspects of pregnancy and childbirth by midwives not considering a woman as a whole being. The fragmentation of the midwifery education program was also a concern for midwifery experts as reflected in responses of in-depth interviews, chapter 5, subsection 5.5.2.6.

A recommendation by the researcher regarding thefragmented midwifery program is to integrate low risk content with high risk content at a SANC curriculum level and in the education of midwifery care in order for midwifery students to view women as whole, and not as a low or high risk problem, also as an attempt to promote a holistic approach in the management of the woman during pregnancy and childbirth. It is not feasible for a student who is doing first year in midwifery to only focus on the normal process of pregnancy and ignore the high risk factors that the woman might present with.

8.2.2.4 **Theory facilitation**

Midwifery education record review for the nursing colleges revealed an inclusion of holism within the objectives of the midwifery curriculum but a limitation in theoretical facilitation and evaluation of psychosocial content as presented in Table 4.9. According to Cioffi's (1997) theory of teaching as described in chapter 4 sub-section 4.6.4, teaching should focus on both knowledge and skills acquisition.The teaching program should offer students an opportunity to use acquired knowledge in the clinical situation, with the assistance of clinical preceptors. The implication is for students to be taught psychosocial care in theory and be placed in antenatal units to apply the theory to practice by assessing women psychosocially and offering them appropriate support.

Based on Cioffi's theory (1997), the researcher's view is that an ideal midwifery education program with psychosocial care includedshould focus on developing the student's assessment skills and decision-making expertise. The researchersuggests the incorporation of the following principles in the overall midwifery education system:

- A partnership between midwifery educators, midwifery researchers and clinicians to jointly promote psychosocial care during childbirth.

- Instilling ethical principles in midwifery education that will encourage the acknowledgement of women's values and beliefs, and as such enhance psychosocial care.
- Establishing an online global psychosocial care network formidwifery education and midwifery practice.
- Developing and implementing a psychosocial assessment tool. The tool should focus on four categories: interviewing skills, exposition of knowledge and comprehension, reflective analysis, interpretation and application to practice, all of which are principles applicable to psychosocial care.
- Incorporation of global standards for midwifery regulation and midwifery education with emphasis on psychosocial care.

There is also evidence of a limitation of psychosocial content within the clinical facilitation and assessment of student midwives within the three nursing colleges in Gauteng Province as explained in chapter 6 (6.3.2) and Figure 6.4, which does not conform to the proposed SANC ratio that is also described in Figure 6.4. This limitation creates a gap between midwifery education and midwifery practice, which ultimately denies a woman's right to psychosocial care.

Denying pregnant women an opportunity for psychosocial care is viewed by the researcher as unethical, as the women's values and beliefs are to a certain extent overlooked. There is also a bit of ignorance around psychosocial care or an oversight on the part of midwives, despite the stated challenges and this is also against the expectations of the midwifery regulating body (SANC).

Furthermore, holistic care should be clearly specified at SANC level in order to address the limitation in psychosocial care at the midwifery education level. Holistic care should be incorporated within the meso-curriculum of the colleges and applied at all levels of midwifery care. This will create an opportunity to include psychosocial care content as part of midwifery education. Once the students are facilitated theoretically and clinically on the psychosocial content, the clinical application at the receiving end will be improved.

8.2.2.5 **Policy making**

The main policy makers are the midwifery education regulating body (SANC) and the various levels of South African Health Departments. It is important that other stakeholders in policy making, which include for example midwives and midwifery students, form a partnership and

together design guidelines that are deemed important as part of policy to manage psychosocial care.

Policy makers shouldensure that midwifery education, midwifery regulation and midwifery practice are designed and governed primarily by midwives and meet global standards; recognizing and incorporating “The National Health Policy Guidelines for improved Mental Health in South Africa” and apply the policy to midwifery care; reducing inequalities in social and economic policies in order to protect and promote women’s rights, choices and autonomy, by also observing safe motherhood as a matter of human rights and social justice; defining psychosocial care performance targets as part of policy; monitoring the antenatal care system and establishing whether the aim and goals of antenatal care are met by service providers as a form of quality assurance; ensuring that the antenatal care system meets women’s expectations and protects their right to informed choice, decision making, privacy, dignity and autonomy.

Psychosocial care should also be included as one of the recommendations in the Saving Mothers Report on Confidential Enquiries into Maternal Deaths in South Africa, as there is evidence that psychosocial risks contribute to maternal morbidity and mortality (Willinck et al, 2000).Women’s voices should be included within the objectives of safe motherhood programs to serve the women’s needs (Grossmann-Kendall, Filippi, De Koninck & Kanhonou 2001; Parry, 2008; Menon et al, 2010), as explained in 5.3.2.5. Women’s responses in this study could contribute to these programs as part of evidence-based practice.

The researcher further recommends that in order to address the shortage of midwives, the policy makers should attend urgently to the South African President’s recent announcement of the revitalization of 105 nursing colleges which were closed a decade ago due to lack of funding as reflected in 6.3.5.

8.2.3 **Objective 3: To Explore and Describe the Awareness and Knowledge of Psychosocial Risk Assessment and Psychosocial Care by Midwifery Care Providers during Pregnancy**

The objective was to explore the perception of psychosocial risk assessment and psychosocial care by midwives during pregnancy which was established through focus group discussions with midwives and obtaining responses through self-reported questionnaires.

Findings

In their responses in group discussions and questionnaire responses, midwives displayedawareness and acknowledgement of the importance of psychosocial assessment of women and offering them psychosocial support during antenatal care. They further highlighted the need for antenatal guidelines on psychosocial care and the importance of incorporating these into routine antenatal care.

Conclusion

Based on the midwives' responses and evidence of the existence of psychosocial risks, antenatal care guidelines for psychosocial care were developed and piloted in the three clinics that participated in the study.

8.2.4 Objective 4: To Explore and Describe the Experiences and Satisfaction of Pregnant Women regarding Psychosocial Care offered during Antenatal Visits

This objective was explored through focus group discussions with pregnant women attending antenatal care in the three clinics that participated in the study. Informal conversations were also held with women in the clinic's waiting room when they indicated a need to be informed or required clarification on specific issues.

Findings

Women acknowledged the physical care offered to them by midwives during antenatal care. They however expressed dissatisfaction with psychosocial care, especially lack of interaction, limited communication and not being well informed about their care. There is evidence of poor efficiency of routine care provided to women in this study which, according to the women's accounts, does not attend to aspects of communication and support.

Conclusion

Several approaches and models for antenatal care were discussed as part of qualitative findings in chapter 5 and chapter 6. The approaches offer midwives an opportunity to address the psychosocial aspect of pregnancy as part of antenatal care.

8.2.5 Objective 5: To Develop Guidelines that would Focus onPsychosocial Risk Assessment and Psychosocial Support during Antenatal Care

Evidence of the existence of psychosocial risks led to the development of a screening tool for psychosocial care (Appendix R). The development of the guidelines was further justified by the midwives'recommendationsin focus group discussions, the responses from experts' interviews and the cross-sectional survey results from midwivesthat there is a need for a tool that could be used for psychosocial assessment and psychosocial support during pregnancy. The guidelines were based on the variables contained in the self-reported questionnaires from women contained in the ALPHA tool (Appendix S).

Conclusion

Midwifery clinical practice involves clinical judgements that are often made within a short span of time and have major implications for the wellbeing of the mother and the baby. Clinical judgement depends on the midwife's knowledge and experience, and its effectiveness is based on the midwife's problem-solving skills and critical decision- making ability. For a midwife to make appropriate clinical judgements, a comprehensive physical and psychosocial assessment and history- taking are necessary.

8.2.5.1 Recommendations for Midwifery Clinical Practice

The researcher is of the opinion that the following principles could be implemented in clinical practice to strengthen psychosocial care in midwifery practice.

8.2.5.1.1 Strenghthening midwifery practice

Psychosocial care in midwifery clinical practice can be strengthened through the implementation of a holistic midwifery care approach; by midwives engaging in multidisciplinary health care partnerships; incorporating prenatal psychosocial assessment guidelines in clinical practice; promoting midwives' professional autonomy by allowing midwives to take charge of midwifery clinical practice and encouraging the realization of midwives' advocacy role by acknowledging women's rights and choices.

8.2.5.1.2 Shortage of midwives

Campaigning globally for a midwifery workforce to address the shortage of midwives; strengthening midwifery by entering into strategic collaborations with international organizations, alliances and networks that share a common vision for the promotion of

women's health; allocating a midwife in each antenatal unit who focuses on offering psychosocial care and identifying a feasible model of antenatal care as described in chapter six, that could be applied within a specific antenatal care context.

8.2.5.2 **Psychosocial support**

Thefindings of this study generally provide evidence regarding a need for psychosocial support for pregnant women. The overall aim of psychosocial care, as described in chapter one, is to promote the women's psychosocial wellbeing and to empower them to develop a positive attitude towards childbirth. In addition to minimizing maternal distress, Feldman (2000) as explained in chapter 1(1.2.7) maintains that psychosocial support also inspires healthier behavior and lifestyles, and discourages behaviours such as smoking, substance abuse and poor nutritional intake, thereby promoting a healthier pregnancy outcome. Assessing and promoting women's psychosocial health does not only improve an individual's health, but also the wellbeing of families, communities and society in general. As such, the researcher supports the implementation of psychosocial care during pregnancy.

Based on the aim of psychosocial support an ideal infrastructure and setting for offering psychosocial support would be through:

The organizational change of maternity services

Providing a maternity setting that is not fragmented but provides continuity of care. This can be achieved through the integration of antenatal, intrapartum, postnatal and neonatal care servicesas illustrated in Figure 8.1, which offers continuity of care.

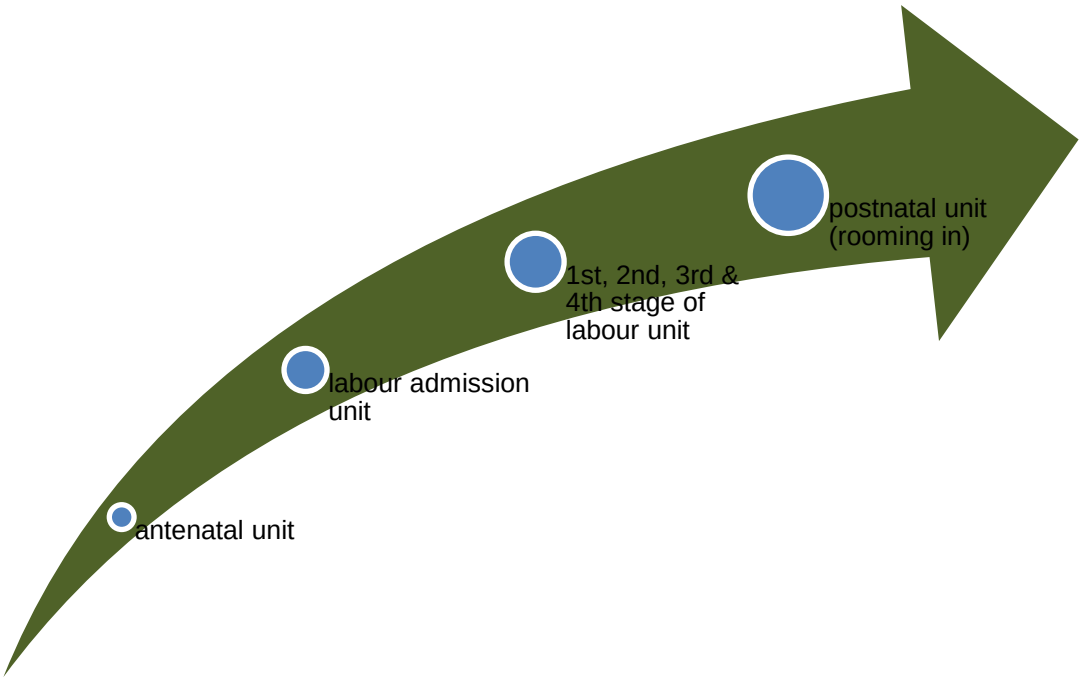

Figure 8.1: The Organization of a Maternity Unit

Support structure

Availability of support structures that includepartners, families, religious institutions, cultural groups, peer groups, civic organizations, political organizations, HIV/AIDS organizations.

Multidisciplinary care approach

A teamcomprising ofnursing, medical, obstetric, nutritional and psychological clinical care services. An ideal team like the recently introduced multidisciplinary in the Health Minister's 10 District Health pilot sites who might initiate the provision of comprehensive holistic care to women as part of the project.

Awareness for psychosocial care

Raising awarenessfor midwives of the need for counseling and psychosocialsupport. programs.

Counselor support

Counselors, including midwives who act as counselors, should be well trained and show commitment, as poor quality service will fail to recruit women, for example, to

considervoluntary testing and counseling (VCT). Counselor supervision and peer support are important, as counseling for HIV is a stressful intervention.

Infrastructure

An ideal location for referral resources is at a community level or a level 1 health care service, which is a context in which this study was conducted. Resources should include referral systems for social and psychological care, for example financial and legal aid services.

Psychosocial support resources

Women may join self-help groups like Wola Nani and Mothers 2 Mothers program, which is described in chapter 6 (6.3.1) for them to have better understanding and greater acceptance of psychosocial interventions.

Support offered to midwives

Strengtheningthe capacity of community health care centers by providing refresher training in psychosocial care for midwives, and making them aware of the importance of attending to the realities of the lives of women in their care in order to meet their needs.

Debriefing sessions to be organized for the midwives in clinical practice to empower midwives to implement and sustain psychosocial care.

In-service education for midwifery unit managers on contemporary leadership styles, for example transformational, quantum, visionary and dynamic leaderships, with supervision and role-modeling aiming at managers being able to provide participatory management , a conducive environment where midwives can provide appropriate antenatal care to women and resolve challenges experienced by midwives in clinical practice.

8.2.5.3 **Guidelines for midwives in clinical practice**

The following guidelines are suggested by the researcher to the midwives offering antenatal care services in order to enhance psychosocial care:

- Explore the women's expectations of care during pregnancy to plan care based on needs.
- Develop a trust relationship by making pregnant women the first concernthrough the establishment of relationships that convey care and concern.

- Provide a high standard of practice and care at all times, acting with integrity and upholding the reputation of midwifery.
- Be honest and open to women in your care by keeping them informed about procedures and the progress of pregnancy.
- Treat women as individuals and respect their dignity.
- Demonstrate personal and professional commitment to equality and diversity by not discriminating against those in your care.
- Recognize and respect the contribution that women make to their own care and wellbeing
- Accommodate the women's language and meet their communication needs.
- Collaborate with others to protect and promote the wellbeing of those in your care.
- Act as an advocate for those in your care, helping them to access the relevant health and social care, information and support.
- Promote family planning to avoid unwanted pregnancies which, if not accepted, often lead to maternal stress.
- Observe and implement the Patient's Rights Charter with regard to informed consent, a healthy and safe environment, confidentiality, participation in decision making that affects the woman's health, opportunity to complain about the health service received and the right to exercise choice of care offered.
- Offering women with specific needs alternative options such as foster care, adoption and termination of pregnancy.
- Apply the Batho Pele Principles as a guideline to psychosocial care reflecting on the principles of courtesy, information, openness and transparency.

8.2.6 **Objective 6: To Pilot the Formulated Guidelines**

This objective complemented the findings of objective 1 which confirmedthe existence of psychosocial risks experienced by women during pregnancy and as perceived by midwives in their care.The formulated guidelines were piloted in the participating clinics by use of a tool (Appendix R).

Findings

The pilot study findings revealed evidence from this study indicating that antenatal care does not consist of a series of medical investigations and monitoring procedures, but is fundamentally about an interaction between two actively participating individuals who bring their respective knowledge and expertise into the relationship. The findings of the clinicians

who implemented the guidelines in the pilot study indicated an acceptance of the guidelines and support for its use as part of routine antenatal care.

Conclusion

To address the woman's psychosocial wellbeing, a tool should be used to assess the pregnant woman's economic, social, psychological and emotional needs, and explore any history of sexual abuse, substance abuse or family violence. The researcher suggests that in order to meet the aim of antenatal care as described by the National Collaborating Centre for Women's and Children's Health and WHO, countries including South Africa should adopt the "focused antenatal approach" of WHO that emphasizes provider-client exchange (Fawoleetal, 2008), as discussed in chapter one, but also adjust the interventions according to the needs of the particular population and the available resources.

8.2.6.1 **Recommendations for psychosocial research in midwifery care**

In order to strengthen and support psychosocial research in midwifery care and to develop a standardized psychosocial assessment tool that meets the minimum criteria for routine antenatal care, which include safety, simplicity, precision and adequate validation, also to close the gap between psychosocial research and midwifery practice, the following are suggested research issues that need to be addressed for psychosocial care:

- To assess women's psychosocial state in a more representative sample
- Explore women's experiences of psychosocial care in a broader context
- Explore psychosocial care resources for referral of women at risk
- To determine other ways of supporting women psychosocially within a context where there is limited access to social and psychological services
- To establish the psychosocial needs and support of pregnant women and families who are HIV positive is recommended.

Long-term issues that could be explored in supporting research in psychosocial care are studies focusing on the outcomes of psychosocial assessment and care on pregnancy and childbirth; the role of prospective fathers during antenatal care as a major source of psychosocial support for the pregnant partner; a study to explore the effect of the classification of high risk on a woman's psychosocial state, and a general study on psychosocial care offered in labour units as suggested by women who participated in focus group discussions.

8.3 LIMITATIONS

The following limitations were acknowledged by the researcher:

8.3.1 The Review of the College's Tests, Examination Papers and Clinical Tools

The non-submission of some of the records for review by college 2 (Table 4.7.a) and nursing college 3 (Table 4.8.a)could have negatively influenced the outcome of the findings of the review.

8.3.2 Women's Survey

A possible limitation for the women's survey is the possibility of respondents withholding social and psychological factors due to the sensitive nature of the topic. A comparison of women's responses in the questionnaire and the antenatal record might have also validated the information provided by women. This was not done as it was not within the objectives of this study.

8.3.3 Midwives' Survey

The limitation that occurred from the self-reported questionnaire was that some respondents provided incomplete demographic data and some did not complete some parts of the closed and open-ended questions which led to difficulty in data analysis.

8.4 Pilot Study

The pilot study tested acceptability by clinicians and not effects on women and the outcomes of pregnancy.

8.8 CONCLUSION

Chapter 8 discussed conclusions, guidelines and recommendations for midwifery education and clinical practice.

The findings provided a rich dataset from multiple data sources revealing a need for psychosocial assessment during antenatal care and confirmed by the findings of the pilot study. The pilot study was a pragmatic action taken in response to the initial results and findings of the study, and reported on the consequences of the action.

The prevalence of psychosocial risk reflected in this study and others, and the benefits of psychosocial interventions clearly indicate the need for psychosocial care during childbirth. Within the context of this study, routine psychosocial care is recommended not only for the

reduction of psychosocial morbidity and mortality, but as an attempt to offer pregnant women antenatal care that is holistic, comprehensive, and is based on needs and expectations.The statement by Williamson et al, (1996) that an expectant woman is not an ambulant pelvis, but a human being with needs and whose soul and body are closely interlocked, provides awareness of the importance of psychosocial care during pregnancy.

Antenatal care serves as a context within which psychosocial assessment and psychosocial care ideally occur. The overall objective of antenatal care is to maintain the woman's physical, mental and social wellbeing, although much of what generally constitutes contemporary antenatal care is based on a medical model within which it developed. Furthermore, antenatal care is typically designed to ensure birth of a healthy infant and to assist the mother in caring for the newborn.

From a midwifery perspective, antenatal care is an integral part of the whole childbearing experience. How a midwife regards antenatal care is crucial to the management of her client's pregnancy. Routine antenatal care, or antenatal care that is focused on somatic conditions, may lead to overlooking a pregnant woman's psychosocial needs and missing an opportunity for intervention and the provision of holistic care.

The purpose of antenatal care might need to be redefined as the current practice focuses on routine screening and investigations. If shown to be relevant and effective, the end product should be the incorporation of the available evidence into the national guidelines for best practice.

"Improving public service delivery is not a once off exercise. It is an ongoing and dynamic process. As standards are met they should be progressively raised. This study marks only the first stage in the process of acknowledging psychosocial care during pregnancy and childbirth. There is a great deal to be done and the process might sometimes be frustrating, but the venture is one of the most worthwhile and rewarding aspects of health care. The need seems urgent, and there is no time to lose" **(Batho Pele White Paper, 1997)**

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APPENDIX A

- Ethical Clearance

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
R14/49 Mathibe-Neke

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER M081013**
PROJECT	Psychosocial Risk Asessment by Midwives during Antenatal Care: A Focus on Psychosocial Support
INVESTIGATORS	Mrs JM Mathibe-Neke
DEPARTMENT	Dept of Nursing Education
DATE CONSIDERED	08.10.31
DECISION OF THE COMMITTEE*	Approved unconditionally

Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.

DATE 08.12.05 **CHAIRPERSON** .....
(Professor P E Cleaton Jones)

*Guidelines for written 'informed consent' attached where applicable

cc: Supervisor : Dr G Langley

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University.
I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to a completion of a yearly progress report.**

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES...

APPENDIX B

- Gauteng Department of Health Permission Letter

SECTION D – REVIEW RECOMMENDATION AND APPROVAL

Wits PhD in Nursing student, J.M. Mathibe-Neke's research study: "Psychosocial Risk Assessment by Midwives during Antenatal Care: A Focus on Psychological Support"

REVIEW

Reviewed by:

Mr. Siviwe Mkoka

Deputy Director: Policy and Research

Date: 07/04/2009

APPROVAL

Approved / ~~not approved by~~:

Ms. S. le Roux

Director, Policy, Planning and Research: Gauteng Provincial Department of Health

Date: 7/04/2009

APPENDIX C

- South African Nursing Council Permission Letter

Johanna Mathibe-Neke

From: Sizeni Mchunu [smchunu@sanc.co.za]
Sent: Wednesday, August 05, 2009 11:59 AM
To: Johanna Mathibe-Neke
Cc: Judith Bruce; Christine Dioke
Subject: RE: research proposal

Dear Ms Mathibe-Neke

Thank you for your mail. Thank you for clarifying your requst

Kindly note that:

1. **Regulations**

Regulations for midwifery training are contained in GG NO. R254 and GG NO. R212 and are obtainable at a small price in the Sales Department of the Council. You could actually save on time and money if you make a copy from the department as I would imagine that it has a package of current regulation for functionality as well as teaching of students particularly post-grads

2. **Scope of Practice**

The current scope of practice a midwife is contained in GG NO. R2895.

3. **Curriculum**

I am not certain about the curriculum that you seek as copies of curricula that the Council has are individual nursing education institutions' original copies which the Council cannot pass on to an individual. It would be proper and legal if you approach an individual school of choice for this because it seems like you need one **curriculum .**

4. **Tests**

The Council does not have midwifery tests as it does not train. You can only obtain those at a training institution that offers the midwifery programme

5. **Midwifery examination papers**

I would like to forward this request to the manager of examination section, Ms Dioke, who I am confident will assist you

It is hoped that this does assist you

Sincerely

8/5/2009

SA Mchunu (Ms)
Acting Registrar & CEO
South African Nursing Council
012-4201059/60 Tel.
012-4269554 Fax

From: Johanna Mathibe-Neke [mailto:Johanna.Mathibe-Neke@wits.ac.za]
Sent: Wednesday, August 05, 2009 11:05 AM
To: Sizeni Mchunu
Subject: research proposal
Importance: High

HI Sizeni

The following are the required documents as stipulated in the research proposal that was submitted to SANC on the 12th January 2009 and e-mailed again in March:

The Midwifery Training Regulations including the Scope of Practice and curriculum, the midwifery tests and examinations set by the South African Nursing Council for the period 2004 to 2009.

I hope this will clarify the situation.

JM Mathibe-Neke

Department of Nursing Education

Wits University

Live your best life!

This communication is intended for the addressee only. It is confidential. If you have received this communication in error, please notify us immediately and destroy the original message. You may not copy or disseminate this communication without the permission of the University. Only authorized signatories are competent to enter into agreements on behalf of the University and recipients are thus advised that the content of this message may not be legally binding on the University and may contain the personal views and opinions of the author, which are not necessarily the views and opinions of The University of the Witwatersrand, Johannesburg. All agreements between the University and outsiders are subject to South African Law unless the University agrees in writing to the contrary.

APPENDIX D

- Nursing Colleges Permission Letter (D1 and D2)

APPENDIX D1

Department of Health
Ann Latsky Nursing College

Enquiries: PS Zibi

Lefapha la Maphelo
Departement van Gesondheid
Umnyango wezeMpilo

Tel (011) 644-8900
Fax (011) 726 2619

Date: 19th June2009

Ms JM Mathibe – Neke
University of Witwatersrand
7 York Road
Parktown

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

The Research Committee meeting held on the 11th June 2009, refers:

The Committee has accepted your research proposal entitled "Psychosocial risk assessment bymidwives during antenatal care: Afocus on psychosocial support . Attached, a copy of the completed assessment document for your attention:

During your research study, all the research and ethical principles must be strictly adhered to. Upon completion of your study, a copy of your completed dissertation must be donated to the College for use by personnel.

Please contact the following academic head in order to make the relevant arrangements for your research study:

- Ms E Waterson
- (011) 644- 8957

We wish you success with your research endeavors!

EE HARMS
PRINCIPAL

P. ZIBI
DEPARTMENTAL HEAD BASIC COURSES
CHAIRPERSON: RESEARCH COMMITTEE

APPENDIX D2

03/03 2009 08:23 FAX 0123195899 002

DEPARTMENT OF HEALTH

SG LOURENS NURSING COLLEGE

PRIVATE BAG X765, PRETORIA, 0001

MS. S.P.M. MOTLOUTSI

TEL NO: (012) 319-5748 FAX NO: (012) 319-5742 E-MAIL: paalini.naidoo@gauteng.gov.za

ATT : Ms. J.M. Mathibe-Neke
University of Witersrand
7 York Road
Parktown
2193

RE: RESEARCH PROPOSAL APPROVAL

This communiqué is to confirm, in principle, that your study will not interfere with the operation of the College, thus permission is granted.

Yours sincerely

MS. K.M.D. RAMBAU
PRINCIPAL

24 February 2009.
DATE

APPENDIX E

- Permission Letter from the Province

RESEARCH CLEARANCE CERTIFICATE

Research Project Title: Psycho-social risk assessment by midwives during antenatal care – Focus on psycho-social support

Research Project Number: 010/2009

Name of Researcher(s): Ms J. Mathibe-Neke

Division/Institution/Company: Wits University (Dept. Of Nursing Education)

Qualification(s) of Researcher(s): Various

DECISION TAKEN BY THE EKURHULENI HEALTH DISTRICT ETHICS PANEL (EHDEP)

- *THIS DOCUMENT CERTIFIES THAT THE ABOVE RESEARCH PROJECT HAS BEEN FULLY APPROVED BY THE EHDEP. THE RESEARCHER(S) MAY THEREFORE COMMENCE WITH THE INTENDED RESEARCH PROJECT.*
- *NOTE THAT THE RESEARCHER(S) WILL BE EXPECTED TO PRESENT THE RESEARCH FINDINGS OF THE PROPOSED RESEARCH PROJECT AT THE ANNUAL EKURHULENI RESEARCH CONFERENCE HELD IN JULY/AUGUST.*
- *THE ETHICS PANEL WISHES THE RESEARCHER(S) THE BEST OF SUCCESS.*

(DR J. SEPHAYA)

CHAIRPERSON: EKURHULENI HEALTH DISTRICT ETHICS PANEL

Dated: 29th June 2009

(B Mathipa)

RESEARCH COORDINATOR: EKURHULENI METROPOLITAN MUNICIPALITY

Dated: 29 June 2009

(DR S. Ngcobo)

RESEARCH COORDINATOR: GAUTENG DEPARTMENT OF HEALTH (EKURHULENI REGION)

Dated: 30/06/09

APPENDIX F

- Permission Letter from the Clinics (F1 and F2)

APPENDIX F1

Department of Health
Lefapha la Maphelo
Departement van Gesondheid
Umnyango wezeMpilo
JOHANNESBURG HEALTH DISTRICT

health for a better life

Office of the District Director
Tel: 011 694 3710
Fax: 011 693 3815
Email: carvie.kula@gauteng.gov.za

Enquiries: Ms C. Terblanche

Ms J. M. Mathibe-Neke
University of the Witwatersrand
7 York Road
Parktown
2193

Dear Ms Mathibe-Neke

RE: PERMISSION TO DO RESEARCH ON PSYCHOSOCIAL RISK ASSESSMENT BY MIDWIVES DURING ANTENATAL CARE – A FOCUS ON PSYCHOSOCIAL SUPPORT

Your application to do research at Community Health Centre has been approved.

Wishing you success and expecting to receive a report on completion of the research.

Yours faithfully

Mrs. Carvie Kula
Acting District Director
30/03/09

APPENDIX F2

UNIVERSITY OF WITWATERSRAND
FACULTY OF HEALTH SCIENCES
7 YORK ROAD
PARKTOWN
JOHANNESBURG
2193

RESEARCH SITES AGREEMENT

WE (INSTITUTION NAME)..... HEALTH CENTRE

OFFER (RESEACHER NAME)..... Johanna Mathibe-Neka

PERMISSION TO CONDUCT RESEARCH AT THIS INSTITUTION.

AN AGREEMENT WITH THE RESEARCHER IS BASED ON THE CONDITION THAT THE DATA COLLECTED WILL BE TREATED WITH THE HIGHEST CONFIDENTIALITY AND WILL SOLELY BE USED FOR THE INTENDED STUDY ONLY.

RESEARCHER SIGNATURE:.....

RESEARCH OFFICER/ RESEARCH CORDINATOR / HOD

..... HPM/ Gruno RC

DATE..... 2009.02.23

APPENDIX G

- Criteria for Midwifery Experts

CRITERIA FOR MIDWIFERY EXPERTS:

- Specialist in the field/ discipline (body of knowledge)/Advanced Midwife.
- Specialist Academic, lecturer in the University or Nursing College facilitating midwifery program.
- The Advanced Practitioner (Clinical specialist/clinical facilitator).
- The Expert Midwifery Course Administrator that is HOD for Midwifery in a University or a Nursing College.
- 5 year Experience or more.

APPENDIX H

- Permission Letter from the ALPHA Group

Johanna Mathibe-Neke

From: Carroll, Dr. June [jcarroll@mtsinai.on.ca]
Sent: Wednesday, October 22, 2008 11:27 PM
To: Johanna Mathibe-Neke
Subject: RE: copyright applicatio

Hi,

You are welcome to use aspects of the ALPHA tool as long as you reference us. Remember that it is no longer a validated tool once only sections of it are used.

For our interest, what type of project are you doing?

June Carroll

From: Johanna Mathibe-Neke [mailto:Johanna.Mathibe-Neke@wits.ac.za]
Sent: October 21, 2008 7:11 AM
To: jcarroll@mtsinai.on.ca
Subject: copyright applicatio
Importance: High

Hi Dr June

I am a lecturer at the University of Witwatersrand in South Africa. I would like to apply for copyright for using some aspects within the Antenatal Psychosocial Health Assessment Tool (ALPHA). I hope you will be able to assist me. My e-mail address is Johanna.mathibe-neke@wits.ac.za

Thanking you in advance. Regards.

JM Mathibe-Neke

Department of Nursing Education

Wits University

This communication is intended for the addressee only. It is confidential. If you have received this communication in error, please

APPENDIX I

- Information and Consent for Women's Questionnaire

INFORMATION AND CONSENT FOR PREGNANT WOMEN'S PARTICIPATION IN THE STUDY

Dear mother to be

My name is Johannah Mathibe-Neke. I am currently studying for a PhD Degree in the Department of Nursing at the University of Witwatersrand. I am conducting a study onpsychosocial risk assessment by midwives during antenatal care, with a focus on psychosocial support.

I would like to invite you to share your experience and expectations regarding psychosocial support during antenatal care. The purpose of the study is to establish the extent of psychosocial risk assessment and psycho social support by midwives during pregnancy.

Why are you selected as a participant?
You are selected because you are pregnant at this period and you are attending antenatal care at this unit where the study is being conducted. The Researcher also believes that you have information that will assist the midwives in planning and offering antenatal care in such a way that it meets your needs.

Procedure and length of time needed
You need to respond to questions by completing a questionnaire. This will take 10 minutes of your time but there is no time restriction as you may give as much information as you are able to.

Discomforts or inconveniences
None, as the questionnaire will be administered within your waiting period when visiting the clinic, in a familiar environment.

Benefits
The development and implementation of antenatal guidelines aiming at an effective and acceptable care based on the needs of pregnant women.

How confidentiality, anonymity and privacy will be maintained
Participants will be kept anonymous. Data will be coded with numbers and no names. All information collected will be stored by the researcher who will use it sorely for the purpose of the intended study.

Right of participant to continue or withdraw
Participation is voluntary. You also have the right to refuse or terminate from participation at any point of the process, without fear or recrimination.

For enquiries contact: Researcher 011 488 4275 / 0721545086
HREC Secretary (Anisa Keshav) 011 717 1234

I HAVE CAREFULLY READ AND UNDERSTAND THE ABOVE INFORMATION. MY SIGNATURE BELOW, INDICATES THAT I HAVE DECIDED TO PARTICIPATE.

……	…….
Date	Signature of participant
……	…….
Time	Signature of researcher

APPENDIX J

- Special Request to the South African Midwifery Society Association (SOMSA)

A SPECIAL ADRESS TO SOMSA CONGRESS ORGANISERS

I am currently studying for a PhD with the University of Witwatersrand. My study is on "***Psychosocial risk assessment by midwives during antenatal care: A focus on psychosocial support.***" As part of my protocol, I need to collect data from various sources i.e. midwifery training records from South African Nursing Care and Gauteng nursing colleges that offers a 4 year Diploma course in Nursing, conduct focus group discussions and administered questionnaires with pregnant women in antenatal clinics and midwives.

The Annual Congress of Midwives of South Africa, where I have already presented two papers, was earmarked as one of the ideal setting for data collection through a self-administered questionnaire, pertaining to psychosocial risk assessment, as midwives will be represented from all nine South African Provinces.

I will as such, in addition to my presentation, like to be offered an opportunity toexplore this concept during the Congress. I have obtained a permission letter fromGauteng Department of Health and has obtained Ethical Clearance from the EthicsCommittee of Witwatersrand University. The questionnaire will take ± 10 minutes and can be administered during tea or lunch break. Participation is voluntary. Anonymity and confidentiality will be maintained. The findings of the questionnaires will be analyzed and may be shared with the delegates in a short presentation.

Attached find the Ethics clearance form, a consent form for participation addressed to midwives and the data collection tool (questionnaire).

Thanking you in advance

Yours Sincerely
Johannah Mathibe-Neke

APPENDIX K

- **Midwives Information and Consent for a Questionnaire**

QUESTIONNAIRE CONSENT FORM MIDWIVES

Dear Midwife:

You are invited to complete a questionnaire on your experiences regarding psychosocial risk assessment and psychosocial support during pregnancy.

The purpose of this questionnaire is to establish the extent of psychosocial risk assessment and psychosocial support by midwives. Your participation is voluntary.

Your individual responses will be kept confidential and in any reporting will not be connected with you as an individual, nor will your participation have any negative impact on your work.

There are no known anticipated risks to you by participating, the questionnaire does take about 10 minutes to complete.

The findings of your responses will be presented to you on the last day of theMidwives Congress.

If you agree to participate, please sign and date below, complete the questionnaire and submit it to the Administrator.

Signed…… Date…….

Thanking you in advance

J M Mathibe-Neke

……..

APPENDIX L

- **Midwives Questionnaire**

THE MIDWIVE'S PERCEPTION OF PSYCHOSOCIAL RISK ASSESSMENT AND PSYCHOSOCIAL SUPPORT DURING PREGNANCY

Kindly answer the following short questions. This will assist with an appropriate plan regarding the midwives interventions for psychosocial risk assessment and psychosocial support during pregnancy.

1. **Province (Tick the appropriate response):**
   Mpumalanga…….Limpopo…….Gauteng…….

   KZN……..North West……Eastern Cape……..

   Western Cape……Northern Cape……..Free State……..

2. **Duration of your practice in a midwifery unit:**
   0-2yrs…… 2-4yrs…… 4-6yrs…....
   6-8yrs…….. 8-10yrs…….. 10yrs & above……

3. **Area of practice (indicate by a cross the area where you were placed for the longest period):**
   Antenatal unit…. …….labour unit……postnatal unit…….
   Neonatal unit ……Other .....

4. **List the psychosocial risks/problems that you encounter / have encountered during your management of a pregnant woman**

……
……
……
……

5. **Indicate any intervention measures that you carried out once a psychosocial risk or problem was identified**

……

……

……

……

6. **Rank your perception about psychosocial risk during pregnancy. Is it addressed:**

a. Adequately…… b. moderately…… c. Not at all……

7. **If you selected b or c, what could be the reasons or factors contributing to this?**

……..

……..

……..

……..

8. **Was psychosocial risk assessment and psychosocial support during pregnancy adequately addressed during your training as a midwife?**

If YES, states the psychosocial aspects that were addressed as part of midwifery education.

……..

……..

……..

……..

APPENDIX M

- Interview Consent for Midwives' Focus Group Interview

10 Robyn Avenue
Naturena
2095

2008.11.13

Dear Colleague

RE: INVITATION TO PARTICIPATE IN A FOCUS GROUP INTERVIEW FOR RESEARCH

Title: Psychosocial risk assessment by midwives during antenatal care: A focus on psychosocial support

My name is Johannah Mathibe-Neke. I am undertaking a research project as a requirement towards a PhD Degree with the University of Witwatersrand. The main purpose of the research is to establish the extent of psychosocial risk assessment and the provision of psychosocial support by midwives during antenatal care.

The research will explore the perception of midwives regarding psychosocial risk assessment and psychosocial support during pregnancy. The findings will be used to develop recommendations and guidelines for psychosocial risk assessment and psychosocial support during antenatal care.

You were selected to participate in this study because you are a registered midwife who practices in an antenatal unit where the research is being done. I believe that you are a relevant source of the information that I need as you meet the criteria for participation.

An assistant moderator will take notes and the interview will also be tape recorded and transcribed verbatim later to ensure objectivity of the study. All information will be confidential. The names of the participants will not be reflected in any of the transcripts to maintain anonymity and confidentiality. The transcripts will be released to authorized people only for research purpose. After transcription the audiotapes will be stored for review and will later be destroyed after data has been finally captured.

Note that participation in the interview is voluntary and you may withdraw at any point without any penalty or prejudice to yourself.

There will be an average of 5 to 10 participants in a group, who will be interviewed together. The interview will last for ± an hour and half. There are no right or wrong answers in a focus group interview as you have to offer your point of view with regard to the topic. You do not need to agree with others, but you should listen respectfully as others share their views. My role as the interviewer will be to guide the discussion.

Date of interview: ----------

Time: ----------

Venue: ----------

Refreshments will be served.

Please confirm attendance and give a written consent for the interview by completing the attached form and return by the 31st March 2009. Attached please find a reply and consent form and the information sheet regarding focus group interview.

I very much look forward to speaking to you and thank you in advance for your assistance in this project.

Yours Sincerely
…….
J M Mathibe-Neke

Reply and Consent Form

To: Johannah Mathibe-Neke
Fax: 011 642 4109
Tel no: 011 488 4275
E-mail: johanna.mathibe-neke@wits.ac.za

Re: Participation in research

Thank you for inviting me to participate in a focus group interview aimed at establishing the extent of psychosocial risk assessment and psychosocial support by midwives during antenatal care.

I understand that the information will be treated confidentially, and that I participate freely and voluntarily, and may withdraw from the interview at any time without prejudice.

Date of interview……..

Time of interview…….

I have carefully read and I understand this agreement, and I freely and voluntarily consent and agree to be interviewed.

NAME ----------

SIGNATURE ----------

DATE ----------

Information sheet for focus group interviewees

Dear Colleague,

- I invite you to be a participant in this study as you are part of the research population.
- I belief that you are a relevant source of the information that I need for the study.
- The main goal of this research is to explore and describe your perception of psychosocial risk assessment and psychosocial support during antenatal care .
- The interviews will be recorded and transcribed verbatim to enrich the data collection and ensure that information is not lost. After transcription the audiotapes will be stored for review and will later be destroyed after data has been finally captured
- All information gathered in this interview will be treated with strict confidentiality. The names of the participants will not be reflected in any of the transcripts to maintain anonymity and confidentiality. The transcripts will be released to authorized people onlyfor research purpose that is the supervisor and the statistician.
- A recorder or assistant moderator will be used to ensure objectivity of the study.
- Participation in the interview is voluntary and interviewees may withdraw at any point without penalty or prejudice.
- The focus group will have an average of 5 to 10 participants in a group, who will be interviewed together.
- The focus group will last for ± an hour and half.
- The findings will be used to develop recommendations and guidelines for psychosocial risk assessment and psychosocial support during antenatal care
- Refreshments will be served

Thanking you in advance

…….
J M Mathibe-Neke

APPENDIX N

- Women's Focus Group Interview Guide

FOCUS GROUP INTERVIEW GUIDE FOR PREGNANT WOMEN

An opening question:

Please tell me about the care and support you received from midwives during your antenatal care visits.

Transition question:

What type of care and support did you expect from the midwives? Was the care and support that you received from midwives what you expected?

Key questions:

Did the care and support fulfill your needs?
Is there anything that you do not like about your clinic visits /care?

Ending question:

Is there anything that you wish should be done for you during your antenatal visits?

APPENDIX O

- **Focus Group Interview For Pregnant Woman**

FOCUS GROUP INTERVIEW FOR PREGNANT WOMAN

Dear mother to be:

You are invited to be part of a focus group interview regarding your experience and expectations of psychosocial risk assessment and psychosocial support by midwives during antenatal care.

You are selected to take part in this study as you are currently pregnant and attending antenatal care at this antenatal clinic where the study is being conducted. I need your participation in the interview because the information you provide as a pregnant woman, will help me to establish the extent of psychosocial problems that pregnant women experience and the type of psychosocial support that they need. The information will also help in the formulation of guidelines for improving psychosocial risk assessment and psychosocial support during antenatal care.

Participation is voluntary and you are free to end the interview whenever you wish to, even if the interview has not yet been completed. The interview will take place in a familiar environment which is within the antenatal clinic. About 5 to 10 pregnant women will be interviewed together. The interview will take approximately an hour. There are no right or wrong answers but rather differing points of view. You need to share your experiences and viewpoint even if it differs from what others have said. Keep in mind that we are just interested in negative as positive comments, and at times, the negative comments can be the most helpful.

Notes will be taken and the interview will also be tape recorded to ensure accurate recording of your responses. I assure you that the information from this interview will be kept confidential and will be used for research purposes only. You will have an opportunity to be referred for counseling should a need arise.

I hope that you will participate in this interview and I am thankful for that. Should you have any questions, please contact me or send a please call at **0721545086** or **011 488 4275**

Thank you gifts will be given to you

Yours Sincerely

……
Johanna Mathibe-Neke

CONSENT AGREEMENT

I HAVE CAREFULLY READ AND UNDERSTAND THIS AGREEMENT, AND I FREELY AND VOLUNTARILY CONSENT AND AGREE TO BE INTERVIEWED

NAME (PLEASE PRINT): ……

SIGNATURE: ……

WITNESS SIGNATURE: ……..

DATE: ……

APPENDIX P

- **Interview Guide for Midwives**

FOCUS GROUP INTERVIEW GUIDE FOR MIDWIVES

An opening question:

Please tell me about your understanding of psychosocial risk assessment during pregnancy

An introductory question:

Is it important for you as a midwife to assess a woman psychosocially during pregnancy? Please elaborate, explain further or justify your response.

A transition question:

Have you ever had an opportunity for assessing a woman psychosocially during pregnancy?

Key questions:

Please share your experiences of psychosocial risks during pregnancy, personal or work related; What are the common psychosocial risks that you ever encountered during your midwifery practice? What interventions did you implement if a psychosocial risk has been identified?

Ending question:

According to your opinion, should psychosocial support be incorporated within routine antenatal care? Is there anything that you would like to share regarding psychosocial risk assessment and psychosocial support during antenatal care?

Thank you for your contribution!

APPENDIX Q

- **Interview Guide for Midewifery Experts**

SEMI-STRUCTURED INTERVIEW GUIDE FOR MIDWIFERY EXPERTS

1. Can you please share your viewpoint regarding psychosocial care during pregnancy?

2. In your opinion, is this aspect of midwifery care adequately addressed?

3. Do the South African Nursing Council Regulations for midwifery education include psychosocial assessment and psychosocial support?

4. Do you think that the College/University is designed to meet this aspect?

5. Are there any guidelines in the Scope of Practice for midwives (R2598) which reflects psychosocial care?

6. Do the formative and summative clinical tools used for midwifery education include outcomes which measure or test psychosocial care?

7. Do you think that there is clinical application of psychosocial assessment and psychosocial support by midwives during antenatal care?

8. Your viewpoint regarding the existing research on psychosocial assessment and psychosocial support during pregnancy. Published or unpublished.

9. Can you make any recommendations for psychosocial care during pregnancy?

APPENDIX R

- **Pilot Tool**

Follow-up plan:

- ☐ Supportive counseling by provider
- ☐ Prenatal education
- ☐ Smoking cessation resources
- ☐ Addiction treatment programmes
- ☐ Social Worker
- ☐ Psychologist / psychiatrist
- ☐ Therapist / marital / family
- ☐ Womens' helpline / shelter
- ☐ Other

COMMENTS:

.....

.....

.....

.....

.....

Psychosocial risk assessment during antenatal care:

A Guideline for midwives in Gauteng Province

NB: Mark the appropriate response. To be completed for all pregnant women as part of assessment during antenatal care. Review during each follow up visit. The "comment" column should be used to elaborate on responses if a need arises.

(Please consider the sensitivity and confidentiality of this information)

NAME: .....

CONTACT NO: .....

Date completed: .....

Signatures:

Midwife: .....

Pregnant woman: .....

Psychosocial Risk Factor	Response			Comment
If you had to change the timing for this pregnancy, would you want it to happen earlier, later or not at all?	Earlier	Later	Not at all	
Is the baby's father happy about the pregnancy?	Yes	No father	Not sure	
Are you married to the baby's father?	Yes	Traditional	No	
Are you currently living with the baby's father?	Yes	Sometimes	No	
Do you have any problems in your relationship?	Yes		No	
Are you employed?	Yes		No	
Who supports you financially?	Partner	Friend	Family	
Do you have a car or access to transport in case of emergencies?	Yes		No	
Do you have access to a telephone?	Yes		No	
Do you have a family member who supports you during this pregnancy?	Yes		No	
Do you or your partner smoke?	Yes		No	
In the past few months, have you or your family used drugs or alcohol?	Yes	Sometimes	No	
Have you suffered from any form of abuse during this pregnancy?	Yes		No	
Do you have any fears or anxiety about this pregnancy?	Yes	Unsure	No	
Do you have any problem that prevents you from attending antenatal clinic?	Yes		No	
How do you rate your current stress level?	High	Low	Medium	
Do you feel unsafe where you live?	Yes		No	
Have you ever had emotional problems, consulted a psychiatrist or therapist?	Yes		No	
Do you have problems at work or school?	Yes		No	
Do you want to keep this pregnancy?	Yes	Not sure	No	

APPENDIX S

- **Questionnaire for Women**

Prenatal psychosocial self-report questionnaire for women

The statements below have been made by pregnant women to describe themselves. Read each statement and indicate your response by ticking either a Very much so, Moderately so, Not at all or a **YES** or **NO** for each statement as applicable to your situation. The information will be used to assist your midwife to provide individualised quality health care to you, based on your needs. Your information will be kept confidential.

Date…….Age:…… Duration of pregnancy (months)……

Statements	**Very much so**	**Moderately so**	**Not at all**
Feelings / emotions			
1.This is a good time for me to be pregnant			
2. My partner / husband and I talk about the baby			
3. It's hard for me to get used to changes brought about by pregnancy			
4. My family is happy about my pregnancy			
5. It's difficult for me to accept this pregnancy			
6. Do you feel isolated, lonely and alone			
7. Other			
Social support / work environment	**YES**		**NO**
1.Do you have someone who shows concern for your problems?	Y		N
2. Do you have transport to access the clinic / hospital?	Y		N
3. Do you have access to a telephone?	Y		N
4. Do you work long hours or use heavy equipment at work?	Y		N
5. Do you have problems that keep you from health care appointments?	Y		N
6.Do you or your partner use alcohol or tobacco/ other drugs	Y		N
7. Are you exposed to chemicals or drugs at work?	Y		N
Family violence	**YES**		**NO**
Did your spouse ever scare or hurt you?	Y		N
Do you ever feel frightened by what your partner says or does?	Y		N
Have you ever been hit/pushed/slapped by your spouse?	Y		N
Has your spouse ever humiliated you or psychologically abused you in other ways?	Y		N
Have you ever been forced to have sex against your will?	Y		N
Life events	Y		N
1. Have you recently experienced a stressful situation, if yes, tick below:	Y		N
1.1 Death of a spouse or family member	Y		N
1.2 Divorce or marital separation	Y		N
1.3 Retrenchment or fired from work	Y		N

1.4 Have you been a victim of rape or sexual assault	Y	N
1.5 Have you ever experience any pregnancy loss?	Y	N
2. Was the pregnancy planned?	Y	N
3. Have you ever been sick during this pregnancy?	Y	N
If yes, what was the illness?		
4. Have you ever attempted suicide?	Y	N
5. Have you ever been diagnosed with a mental health condition?	Y	N
6. Have you been hospitalised for a mental health problem?	Y	N
7.Did you attend any mental health counselling session?	Y	N

Psychosocial risks (as recorded by midwife on antenatal card):

1.

2.

3.

Provider Summary

Once the woman has completed this form, the following approach will be used to note the woman's response as part of data analysis:

Statements	**Possible provider comments**
Feelings / emotions	
1.This is a good time for me to be pregnant	*Pregnancy planned, unplanned, unwanted*
2. My partner / husband and I talk about the baby	*Support or couple dysfunction*
3. Its hard for me to get used to changes brought about by pregnancy	*Adjusted or failure / difficulty to emotionally adjust to pregnancy*
4. My family is happy about my pregnancy	*Support or family dysfunction*
5. Its difficult for me to accept this pregnancy	*Accepted, unplanned, wanted, unwanted*
6. Do you feel isolated, lonely and alone	*Supported, lack of supported*
7. Other	
Social support / work environment	
1. Do you have someone who shows concern for your problems?	*Support, lack of support*
2. Do you have transport to access the clinic / hospital?	*Available /lack of transport facilities*
3. Do you have access to a telephone?	*Communication / lack of communication*
4. Do you work long hours or use heavy equipment at work?	*Difficulties at work*
5. Do you have problems that keep you from health care appointments?	*None or other difficulties*
6. Do you or your partner use alcohol or tobacco/ other drugs	*None or substance abuse*
7. Are you exposed to chemicals or drugs at work?	*Exposure or non-exposure to terratogenic chemicals*
Life events	
1. Have you recently experienced a stressful situation, if yes, tick the experienced event below:	*Identify any recent stressful life event*
1.1 Death of a spouse or family member	
1.2 Divorce or marital separation	
1.3 Retrenchment or fired from work	
1.4 Have you been a victim of rape or sexual assault	
1.5 Have you ever experience any pregnancy loss?	
2. Was the pregnancy planned?	*Planned,unplanned,accepted, ,unaccepted*
3. Have you ever been sick during this pregnancy?	*Existing illness or none*
4. If yes, what was the illness?	*Identify physiological and psychosocial impact on pregnancy*
3. Have you ever attempted suicide?	*Suicidal tendencies, depression*
4. Have you ever been diagnosed with a mental health condition?	*Previous mental problems*
5. Have you been hospitalised for a mental health problem?	*Management and outcome*
6. Did you attend any mental health counselling session?	*Prognosis of the mental problem*

FOLLOW UP PLAN

- ☐ Supportive counselling by provider
- ☐ Nutritionist
- ☐ Addiction treatment program
- ☐ Social worker
- ☐ psychotherapist/ marital, family therapist
- ☐ Assaulted women's helpline
- ☐ Legal advice
- ☐ Referral for employment stress
- ☐ Prenatal education program
- ☐ Support group for pregnant women
- ☐ Smoking cessation resources
- ☐ Psychologist / psychiatrist
- ☐ Transport and telephone facilities
- ☐ Other

Adapted with permission from the Antenatal Psychosocial Health Assessment (ALPHA) instrument. The ALPHA Group, April, 2005. Department of Family and Community Medicine, University of Toronto. (http://dfcm19.med.utoronto.ca/research/alpha)

APPENDIX T

- **Consent for Expert Interviews**

INVITATION AND CONSENT FOR AN INTERVIEW

Dear Colleague,

RE:PSYCHOSOCIAL RISK ASSESSMENT BY MIDWIVES DURING ANTENATAL CARE: A FOCUS ON PSYCHOSOCIAL SUPPORT

My name is Johanna Mathibe-Neke, a lecturer in Women's Health in the Nursing Department of the University of Witwatersrand. As an experienced Midwifery educator, Midwifery Clinical Instructor and/or Advanced Midwife Practitioner, I sincerely believe that you are in a position to share your opinion regarding psychosocial assessment and psychosocial care during childbirth. As such, your perception, expert opinion and input would greatly assist in establishing the extent of psychosocial assessment and psychosocial support during antenatal care.

I will also appreciate your recommendations regarding psychosocial risk assessment and psychosocial support during childbirth. The purpose of the study is to establish the extent of the implementation of psychosocial assessment and psychosocial care during childbirth. The study is part of the fulfillment of a PhD study requirement by the University of Witwatersrand.

If you agree to participate, you will be asked to kindly allow me to interview you on a date, time and venue suitable to you. With your permission, data will be tape recorded and notes will also be taken by the interviewer. The information will be kept confidential. Your individual response will be anonymously included in a report of findings. Participation is voluntary and you may withdraw at any point without explanation or consequences.

The interview will take approximately 60 minutes. Should you agree, kindly indicate the date, time and venue convenient to you.

Kindly sign below, confirming your agreement to participate in this study.

Your assistance and co-operation is greatly valued.

Yours sincerely,

J M Mathibe-Neke
Tel: 011 488 4275 / 072 154 5086

PARTICIPANT'S AGREEMENT AND CONSENT
(Indepth interview on psychosocial risk assessment and psychosocial support by midwives during antenatal care)

Name and Surname : ……...

Title : ……...

Signature : ……...

Convenient date for interview:……..

Venue (preferred) : ……...

Time (preferred) :……...

Return fax: 011 642 4109 (private); or
Return e-mail: johanna.mathibe-neke@wits.ac.za

THANKING YOU IN ADVANCE

APPENDIX U

- Information for a Pilot Study

Dear Midwife

Reference: **Psychosocial risk assessment by midwives during antenatal care: A Focus on psychosocial** s**upport**

The above titled study was conducted in your clinic during 2009.

A psychosocial risk assessment form is attached for piloting. The questions on the form are suggested ways of enquiring about psychosocial wellbeing. It is used to screen the psychological, social, emotional, economical, alcohol or substance abuse and domestic violence.

The guidelines were developed from the findings of the focus group interviews that were conducted with midwives and pregnant women in your clinic during 2009.The long term plan following piloting is to incorporate the guideline as part of routine antenatal care to complement the currently used antenatal card regarding psychosocial assessment and care. The overall aim is to provide pregnant women with a comprehensive, holistic and individualized care.

The piloting would be done during March, April, May until mid June 2011. The tool is to be used to screen psychosocial risks during the antenatal booking visit. The questions should be reviewed during subsequent visits as a form of continuity of care.

Could you kindly submit a report by end of May in the form of feedback in order to complete the study and forward recommendations to other stake-holders.

Thanking you in advance for participating. Your contribution is very valuable.

Kind Regards

……
J M Mathibe-Neke
johanna.mathibe-neke@wits.ac.za
Contact: 011 488 4275 / 0721545086

APPENDIX V

- Evaluation Tool for Pilot Study

PSYCHOSOCIAL ASSESSMENT AND PSYCHOSOCIAL SUPPORT BY MIDWIVES DURING ANTENATAL CARE:EVALUATION OF A PILOT STUDY

Dear Midwife

I would like to establish your understanding, comfort with, commitment to, interest in using, and the outcome of using the "Psychosocial risk assessment and care tool". Please indicate your degree of agreement with the following statements:

(A = agree; SA = strongly agree; D = disagree; SD = strongly disagree)

a, I understand how to use the antenatal psychosocial assessment tool	A	SA	D	SD
b, I am comfortable with performing antenatal psychosocial assessment	A	SA	D	SD
c, I commit to and support the use of antenatal psychosocial assessment tool	A	SA	D	SD
d, More psychosocial problems were identified by using this tool	A	SA	D	SD
e, The number of referrals increased due to the use of this tool	A	SA	D	SD
f, This assessment improved the wellbeing of pregnant women	A	SA	D	SD
g, The quality of communication between you and pregnant women improved with the use of this tool	A	SA	D	SD
h,In your opinion, are women happy to be assessed using this tool	A	SA	D	SD
i, Barriers were encountered in the implementation of psychosocial assessment and psychosocial care	A	SA	D	SD
k, The assessment should form part of routine antenatal care	A	SA	D	SD

Do you have any further comments regarding the antenatal psychosocial assessment tool or its use?

……

……

……

Thank you for participating in this pilot study. God bless!