

**CARING BEHAVIOUR OF MIDWIVES WHO NURSE WOMEN DURING  
CHILDBIRTH IN BOTSWANA**

**by**

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### DECLARATION:

In accordance with Rule; G5.11.4. I declare that the above-mentioned treatise/dissertation/thesis is my own work and that it has not previously been submitted for assessment to another university or another qualification.

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## **ABSTRACT**

Caring behaviour, which is defined as nurturing another to whom one feels a personal sense of commitment and responsibility, is fundamental to the psychosocial component of midwifery. Midwives ought to show respect, kindness and continuous psychosocial support during childbirth to women, who have the right to receive the highest possible standard of care and to be treated with dignity and respect before, during and after childbirth. However, an increasing number of complaints of the uncaring behaviour of midwives towards labouring women has indicated a problem that has not been fully researched. Therefore, the study aimed to identify and describe caring behaviours in the context of midwives in Botswana; determine the inhibiting factors of caring behaviours of midwives during childbirth; and make recommendations to midwives and unit managers based on Swanson's (1991) Theory of Caring, which might lead to the optimisation of caring behaviour in Botswana midwives.

A quantitative, descriptive research design was followed to answer the research questions, and a structured, self-administered questionnaire, which had been developed by the researcher based on the literature review, was used to capture data. A purposive sampling method was used to select 200 respondents working in maternity units in the Kgatleng and Greater Gaborone regional health districts in Botswana. The questionnaire was evaluated for reliability and validity to ensure that it consistently and accurately measured what it was intended to measure. A pilot study was conducted with 10 midwives who met the criteria for participation in the study to pre-test the feasibility of the questionnaire in preparation for the main study. In addition, ethical principles, such as informed consent, respect for persons, anonymity, confidentiality and beneficence were followed throughout the study.

The questionnaire consisted of questions and statements. It was divided into three sections. Section A: Demographic attributes; Section B: Identification and description of the caring behaviour of midwives; Section C: Determination of the inhibiting factors of caring behaviours in midwifery. The data provided by the respondent's answers to the questionnaires were statistically analysed using the Statistical Package for Social Science (SPSS®): Version 27 with the assistance of a statistician, thereby generating descriptive and inferential statistics.

The results of the data analysis revealed that most of the respondents provided positive responses, thereby indicating caring behaviour in midwifery practice. However, several factors that inhibit the caring behaviour of midwives were identified, such as a shortage of staff, work overload, a poor working environment, the inconsistent selection of staff for professional development, a lack of equipment, the young age of some of the woman (less than 15 years), the parity of the woman (more than one child) and the negative behaviour of many of the women. Therefore, recommendations for midwives and unit managers based on the five processes of Swanson's (1991) Theory of Caring were made that could be used to optimise midwifery care in Botswana.

**Keywords:** caring behaviours, childbirth, midwives, maternity unit and women

## TABLE OF CONTENTS

1.1	Introduction.....	17
1.2	Background and orientation.....	18
1.3	Problem statement .....	23
1.4	Research questions.....	24
1.5	Research objectives .....	25
1.6	Significance of the study.....	25
1.7	Clarification of concepts .....	25
1.7.2	Childbirth .....	26
1.7.3	Maternity unit.....	26
1.7.4	Midwife .....	26
1.7.5	Woman .....	27
1.8	Theoretical framework.....	27
1.8.2	Being with.....	29
1.8.3	Doing for.....	29
1.8.4	Enabling .....	29
1.8.5	Maintaining belief .....	30
1.9	Research design and methods.....	30
1.9.1	Research design .....	30
1.9.1.1	Quantitative research design.....	30
1.9.1.2	Descriptive research design .....	31
1.9.2	Research methods .....	31
1.9.2.1	Population .....	31
1.9.2.3	Target and accessible population .....	32
1.9.2.4	Sampling .....	32
1.9.2.5	Sample .....	32
1.9.2.6	Sample size.....	33
1.9.2.7	Data collection .....	33
1.9.2.8	Data collection instrument .....	34
1.10	Data analysis.....	34
1.11	Pilot study.....	35
1.12	Reliability and validity .....	35

1.13	Ethical considerations .....	36
1.13.1	Informed consent.....	36
1.13.2	Respect for persons .....	36
1.13.3	Privacy, anonymity and confidentiality .....	36
1.13.4	Beneficence.....	37
1.14	Dissemination of results .....	37
1.15	Chapter layout .....	38
1.16	Summary of the chapter .....	38
2.1	Introduction.....	39
2.2	The concept of caring behaviour .....	39
2.3	Theoretical perspectives of caring behaviour .....	40
2.3.1	Watson's (2008) Theory of Caring.....	40
2.3.2	Eriksson's (2002) Theory of Caring.....	41
2.3.3	Swanson's (1991) Theory of caring.....	41
2.4	Caring behaviour as a core aspect of midwifery care .....	42
2.4.1	Women-centred care.....	43
2.4.2	Midwifery values.....	43
2.4.3	Professional skills and knowledge.....	44
2.5	Caring behaviour as viewed by midwives.....	45
2.6	Women's expectations of caring behaviour during childbirth.....	46
2.7	Uncaring behaviour of midwives during childbirth .....	46
2.8	Implications of uncaring behaviour in midwives.....	48
2.9	Midwifery practice standards .....	49
2.10	Overview of the health care system in Botswana .....	50
2.10.1	National Quality Health Standards in Botswana .....	50
2.10.2	Healthcare standards in midwifery practice in Botswana .....	51
2.11	Summary of the chapter .....	52
3.1	Introduction.....	53
3.2	Research objectives.....	53
3.3	Research design .....	53
3.3.2	Descriptive research design .....	54
3.4.1	Study sites.....	55
3.4.2	Research population .....	56
3.4.3	Target population.....	56



3.3.4	Sampling .....	56
3.4.5	Sample .....	57
3.4.6	Sample size .....	57
3.4.7.1	Inclusion criteria .....	57
3.4.7.2	Exclusion criteria .....	57
3.4.8	Data collection method .....	58
3.4.8.1	Data collection process .....	58
3.4.8.3	Administration of the questionnaires .....	59
3.5	Pilot study .....	60
3.6	Data analysis .....	61
3.6.1	Descriptive statistics .....	61
3.6.2	Inferential statistics .....	61
3.7	Quality of the study .....	62
3.7.1	Reliability .....	62
3.7.2	Validity .....	62
3.7.2.1	Face validity .....	63
3.7.2.2	Content validity .....	63
3.8	Research ethics .....	63
3.8.1	Informed consent .....	64
3.8.2	Respect for persons and autonomy .....	64
3.8.3	Anonymity and confidentiality .....	65
3.8.4	Beneficence .....	65
3.9	Dissemination of results .....	66
3.10	Summary of the chapter .....	66
4.1	Introduction .....	67
4.2	Data management and analysis .....	67
4.3	Response rate .....	67
4.4	Presentation, interpretation and discussion of the results .....	68
4.4.1	Section A: Respondents' demographics .....	68
4.4.1.1	Age .....	69
4.4.1.2	Gender .....	70
4.4.1.3	Education level .....	71
4.4.1.4	Years of work experience as a midwife .....	72
4.4.1.5	Years of work experience as a midwife in the same unit/ward .....	73

4.4.1.6	Work location.....	74
4.4.1.7	Work satisfaction .....	75
4.4.2	Section B: Respondents' responses to statements about midwives' caring behaviours.....	76
4.4.2.1	Getting to know the woman .....	77
4.4.2.3	Exploring the woman's needs.....	79
4.4.2.4	Obtaining consent .....	80
4.4.2.6	Ensuring confidentiality at all times .....	82
4.4.2.7	Clear instructions.....	83
4.4.2.8	Being authentically present during childbirth .....	85
4.4.2.9	Putting the needs of the woman first .....	86
4.4.2.10	Keeping the woman informed about her progress.....	87
4.4.2.11	Giving reassurance about the childbirth process.....	88
4.4.2.12	Arranging for the woman to see her relatives .....	89
4.4.2.13	Providing privacy for the woman .....	90
4.4.2.15	Sharing the responsibility with the woman.....	92
4.4.2.16	Keeping relatives informed about the woman.....	93
4.4.2.17	Showing genuine interest .....	94
4.4.2.18	Staying at work to complete a job after the shift has ended .....	95
4.4.2.19	Showing professional intimacy .....	97
4.4.2.20	Creating a calm atmosphere .....	98
4.4.2.21	Attending to the labouring woman's demanding needs .....	99
4.4.3	Section C: Respondents' responses to statements about inhibiting factors affecting midwives' caring behaviour.....	101
4.4.3.2	Work overload .....	102
4.4.3.4	Absenteeism.....	104
4.4.3.6	Poor work environment .....	107
4.4.3.8	Lack of verbal appreciation from supervisors .....	109
4.4.3.9	Inconsistent selection of staff for professional development.....	110
4.4.3.10	Lack of equipment.....	112
4.4.3.11	Lack of transport.....	113
4.4.3.12	Inconsistent following of protocol.....	114
4.4.3.13	Demanding attitude of a woman.....	115
4.4.3.14	Woman with no education .....	117

4.4.3.15	Women with some education .....	118
4.4.3.16	Young age of the woman (<15 years).....	119
4.4.3.17	Older age of the woman (30 years and above) .....	120
4.4.3.19	Marital status of the woman (married, cohabiting).....	122
4.4.3.20	Parity of the woman (first childbirth) .....	123
4.4.3.21	Parity of the woman (more than one childbirth).....	125
4.4.3.22	Negative attitude of the woman .....	126
4.4.4	Relationship between midwives' years of experience and their caring behaviour .....	127
4.4.5	Relationship between the midwives' years of experience and factors inhibiting caring behaviour .....	128
4.5	Summary of the chapter .....	129
5.1	Introduction.....	130
5.2	Summary of results .....	130
5.2.1	Section A: Demographic data .....	130
5.2.2	Section B: Midwives' caring behaviour .....	131
5.2.3	Section C: Factors that inhibiting the caring behaviour of midwives.....	131
5.3	Recommended caring behaviours for midwives and unit managers .....	131
5.3.1	Design of the recommendations .....	132
5.3.2	Development of the recommendations .....	132
5.3.3	Target group for recommendations.....	133
5.3.5	Caring Behaviour 1: Knowing .....	133
5.3.5.1	Operational definition of knowing .....	133
5.3.5.2	Operational indicators of knowing .....	133
5.3.5.3	Criteria for knowing (midwives) .....	134
5.3.5.4	Criteria for knowing (unit managers) .....	135
5.3.6	Caring Behaviour 2: Being with .....	135
5.3.6.1	Operational definition of being with .....	135
5.3.6.2	Operational indicators of being with .....	136
5.3.6.3	Criteria for being with (midwives) .....	136
5.3.6.4	Criteria for being with (unit managers) .....	137
5.3.7	Caring Behaviour 3: Doing for .....	138
5.3.7.1	Operational definition of doing for.....	138
5.3.7.2	Operational indicators for doing for .....	138

5.3.7.3	Criteria for doing for (midwives).....	139
5.3.7.4	Criteria for doing for (unit managers).....	140
5.3.8	Caring Behaviour 4: Enabling.....	141
5.3.8.1	Operational definition of enabling.....	141
5.3.8.2	Operational indicators for enabling.....	141
5.3.8.3	Criteria for enabling (midwives).....	142
5.3.8.4	Criteria for enabling (unit managers).....	143
5.3.9.1	Operational definition of maintaining belief.....	144
5.3.9.2	Operational indicators of maintaining belief.....	144
5.3.9.3	Criteria for maintaining belief (midwives).....	144
5.3.9.4	Criteria for maintaining belief (unit managers).....	145
5.4	Summary of the chapter .....	146
6.1	Introduction.....	148
6.2	Summary .....	148
6.2.1	Research objectives .....	148
6.2.2	Research design and methods.....	148
6.2.3	Results of the data analysis.....	149
6.2.3.1	Respondents' demographics .....	149
6.2.3.3	Factors inhibiting midwives' caring behaviour .....	150
6.3	Conclusions.....	150
6.4	Strengths and limitations of the study.....	150
6.4.1	Strengths .....	150
6.4.2	Limitations .....	151
6.5	Recommendations .....	151
6.5.1	Recommendations for midwifery practice.....	151
6.5.2	Recommendations for midwifery education.....	152
6.5.3	Recommendations for midwifery research .....	152
6.6	Summary of the chapter .....	152

## LIST OF TABLES

Table 1.1: Layout of the research study.....	38
Table 3.1: The target population for the study.....	56
Table 4.1: Response rate .....	68
Table 4.2: Midwives' years of experience/caring behaviour.....	128
Table 4.3: Midwives' years of work experience/inhibiting factors.....	129
Table 5.1: Design of the recommendations.....	132
Table 5.2: Criteria for developing recommendations.....	132
Table 5.3: Operationalising recommended caring behaviour.....	133

## LIST OF FIGURES

Figure 1.1: Swanson's five caring processes .....	28
Figure 4.1: Respondents' age .....	69
Figure 4.2: Respondents' gender .....	70
Figure 4.3: Level of education .....	71
Figure 4.4: Years of work experience as a midwife .....	73
Figure 4.5: Years working in the same unit/ward .....	74
Figure 4.6: Work location .....	75
Figure 4.7: Work satisfaction .....	76
Figure 4.8: Getting to know the woman .....	77
Figure 4.9: Listening attentively to the woman when communicating .....	78
Figure 4.10: Exploring the woman's needs .....	79
Figure 4.11: Obtaining consent .....	80
Figure 4.12: Being honest with the woman .....	81
Figure 4.13: Ensuring confidentiality at all times while attending to the woman .....	82
Figure 4.14: Clear instructions .....	83
Figure 4.15: Being authentically present during childbirth .....	85
Figure 4.16: Putting the needs of the woman first .....	86
Figure 4.17: Keeping the woman informed about her progress .....	87
Figure 4.18: Giving reassurance about childbirth progress .....	88
Figure 4.19: Arranging for the woman to see her relatives .....	89
Figure 4.20: Providing privacy for the woman .....	90
Figure 4.21: Respecting the woman's preferences .....	91
Figure 4.22: Sharing responsibility with the woman .....	92
Figure 4.23: Keeping relatives informed about the woman .....	93
Figure 4.24: Showing genuine interest .....	94
Figure 4.25: Staying at work to complete a job after the shift has ended .....	96
Figure 4.26: Showing professional intimacy .....	97
Figure 4.27: Creating a calm atmosphere .....	98
Figure 4.28: Attending to the labouring woman's demanding needs .....	100
Figure 4.29: Shortage of staff .....	101
Figure 4.30: Work overload .....	102

Figure 4.31: Poor teamwork .....	103
Figure 4.32: Absenteeism.....	105
Figure 4.33: Poor collaboration with colleagues .....	106
Figure 4.34: Poor work environment .....	107
Figure 4.35: Language barrier between the midwife and the woman .....	108
Figure 4.36: A lack of verbal appreciation from supervisors .....	109
Figure 4.37: Inconsistent selection of staff for professional development .....	111
Figure 4.38: A lack of equipment .....	112
Figure 4.39: A lack of transport.....	113
Figure 4.40: Inconsistent following of protocol .....	114
Figure 4.41: Demanding attitude of the woman.....	116
Figure 4.42: Woman with no education .....	117
Figure 4.43: Women with some education .....	118
Figure 4.44: Young age of the woman (<15 years).....	119
Figure 4.45: Older age of the woman (30 or more years).....	120
Figure 4.46: Marital status of the woman (single).....	121
Figure 4.47: Marital status of the woman (married, cohabiting).....	122
Figure 4.48: Parity of the woman (first childbirth) .....	124
Figure 4.49: Parity of the woman (more than one childbirth).....	125
Figure 4.50: Negative attitude of the woman.....	126

## LIST OF ANNEXURES

Annexure A: Letter from RECH (Nelson Mandela University) .....	169
Annexure B: Letter to the Botswana Ministry of Health and Wellness.....	171
Annexure C: Application for approval to conduct human research in Botswana ....	174
Annexure D: Letter of approval/permission from HRDDC .....	187
Annexure E: Letters of request to conduct a study at the DHMTs .....	189
Annexure F: Approval letters from DHMT coordinators, superintendent and hospital managers .....	198
Annexure G: Respondents' information document and consent forms.....	202
Annexure H: Questionnaire .....	212
Annexure I: Editor's declaration .....	217
Annexure J: Turnitin receipt.....	218
Annexure K: Turnitin report .....	219
Annexure L: Permission to submit dissertation .....	220



## **ABBREVIATIONS AND ACRONYMS**

DHMTs	District Health Management Teams
DoH	Department of Health
FPGSC	Faculty of Health Sciences Post Graduate Studies Committee
GGDHMT	Greater Gaborone District Health Management Teams
HRDDC	Health Research Development Division Committee
ICM	International Confederation of Midwives
KRHMT	Kgatleng Regional Health Management Team
LMIC	Low- and middle-income countries
MoHW	Ministry of Health and Wellness
NMCB	Nursing and Midwifery Council of Botswana
NMU	Nelson Mandela University
REC-H	Research Ethics Committee – Human
SPSS®	Statistical Package for Social Sciences
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
WHO	World Health Organisation

## CHAPTER 1

### OVERVIEW OF THE STUDY

#### 1.1 Introduction

Despite the importance of caring behaviour as a human right and standard of midwifery practice, the World Health Organisation (WHO) states that globally, women experience uncaring behaviour when looked after by midwives during facility-based childbirth and indicates it as an increasing problem that needs further research (WHO, 2018b; John, Duke and Esienumoh, 2020:167; Malatji & Madiba, 2020:5-10; Bohren *et al.*, 2017:1750). Moreover, uncaring behaviour not only violates women's rights to respectful care but also has a significant impact on maternal care and the health of women during childbirth and their new-born infants (John *et al.*, 2020:166; Malesela, 2018:2). In the context of midwifery practice in Botswana, the study described in this dissertation, therefore, aimed to identify and describe the caring behaviour of midwives who nurse women during childbirth in Botswana; determine the factors that inhibit or facilitate their caring behaviour and make recommendations for midwives and unit managers that could be used to optimise the caring behaviour of midwives when nursing women during childbirth in Botswana

Caring has been considered the essence of health and a central pillar of nursing and midwifery professions (Khresheh & Barclay, 2019:70). Caring behaviour, which is defined as nurturing another to whom one feels a personal sense of commitment and responsibility, is increasingly promoted, and accepted as part of the women-perceived quality of maternity care. Hence, is fundamental to the psychosocial component of midwifery (WHO, 2018:195-200; ICM, 2018:8-18) because caring behaviour helps women to cope with the birthing process (Swanson, 1991:163, 1993, 1999a).

The studies conducted by Lambert *et al.* (2018:257), Munabi-Babigumira *et al.* (2017:4-20) and Ndwiga *et al.* (2017:10) have shown that even though midwives might be doing their best to care for women in labour, other factors have been identified to prevent midwives from meeting professional standards of care during childbirth. These factors include the lack of an enabling working environment, inadequate resources, a shortage of staff and work overload leading to longer waiting times for women to be

assisted, thereby causing women to feel neglected and abandoned by their midwives and midwives feeling frustration and even burnout (Malatji & Madiba, 2020:6).

## **1.2 Background and orientation**

Caring behaviour during childbirth is a central pillar of the midwifery profession, upholds its status and leads to a good rapport between midwives and labouring women. Caring behaviour includes committed nurturing and respect and autonomy (Khresheh, Barclay & Shoqirat, 2019:1) throughout the childbirth process. In addition, caring behaviour involves midwives showing labouring women kindness and recognition of their humanity and dignity (Swanson, 1991,1993). A caring midwife should be available to the labouring women, thereby conveying supportive care and recognition of their needs during childbirth (ICM, 2018:8-18).

Mårtensson *et al.* (2020:1124) describe caring behaviour as nurturing a valued other to whom an individual feels a personal sense of commitment and responsibility. In addition, Khresheh *et al.* (2019:1) describe caring behaviour as being with others and caring for them with dignity. However, during childbirth, the labouring women experience pain that requires midwives to bring relief and enable the labouring women to feel treated with dignity and respect (Khresheh & Barclay, 2019:70; Cherry 2018:1,2).

The Respectful Maternity Care Charter: The Universal Rights of Childbearing Women (White Ribbon Alliance, 2011; Bowser & Hill, 2010:3-5) indicates that midwives are responsible for ensuring that every woman has the right to the highest attainable standard of maternal healthcare throughout pregnancy, childbirth and the postpartum period. Therefore, midwives are expected to maintain professional standards of sensitive and respectful care for their women during childbirth (WHO, 2018:196-200).

A midwife is expected to be professionally accountable for working in partnership with women, whilst giving the necessary support, care and advice during pregnancy, labour and the postpartum period (ICM, 2018:8-18; Nursing and Midwifery Council of Botswana, 1969:15-21). A professional midwife is expected to make sure that labouring women do not experience physical or emotional harm and are cared for in a safe and comfortable environment during childbirth.

Midwives are members of a caring profession, which legally binds midwives to provide essential care and foster the personal values required for ethical best practices during childbirth, such as respect, trust and dignity. This means that they have intentionally chosen a career of service to other people, which entrenches a code of conduct (Beek, McFadden & Dawson, 2019:5; Larsson & Hill, 2018:812; Malesela, 2018:8; MoHW, 2010:13,70-75). In addition, they need to have the knowledge, skills and competencies, as outlined by the International Confederation of Midwives (2018:195-200). Midwives are governed by a code of ethics that demands the safeguarding of women's dignity, the prevention of physical and emotional harm and a positive attitude in the women due to the availability of a midwife (ICM, 2014:1-3; Republic of Botswana, 1995:15-21).

The availability of midwives during childbirth and consistently meeting women's expectations and needs concerning care is an indicator of caring behaviour. The former leads to labouring women having a positive birth experience. Midwives' emotional support and recognition of the women as a significant being are predictors of a hope-filled attitude and satisfaction in women during childbirth (Anderson *et al.*, 2020:1). Therefore, midwives have the responsibility to show emotional and physical commitment and concern for others during childbirth (MoHW, 2011a:1), which increases the ability of the labouring women to manage the stressful birthing process (Khresheh & Barclay, 2019:71; Ndwiga *et al.*, 2017:11-12). In other words, an environment of respectful, dignified, and ongoing supportive care promotes a positive birth experience (Larsson & Hill, 2018:813; Mukamurigo *et al.*, 2017:9; Bowser & ill, 2010:2-3) despite the pain felt during childbirth. Therefore, for midwifery practice to be functionally embedded within the healthcare system, it needs to be accessible, acceptable, respectful and women-centred (Lohmann, Matter & Ayerle, 2018:53; Lambert *et al.*, 2018:257).

Accessible, acceptable, and respectful woman-centred care requires a caring professional midwife who makes sure that every woman receives the highest standard of care during childbirth. Therefore, Khresheh *et al.* (2019:2) and Al-Maharma *et al.* (2021:5) conducted a qualitative exploratory study to investigate women's perceptions of midwives' caring behaviour during childbirth and found that they perceived caring behaviour as listening in an unbiased and empathetic manner; using the women's preferred language for easy understanding of instructions; and respecting the

women's opinions and choices. Moreover, midwives' understanding of women's caring preferences during childbirth and caring needs may enhance more satisfying birth experiences and positive health outcomes.

Positive birth outcomes decrease women's complaints about the uncaring behaviour of midwives in facility-based childbirth. However, Khresheh *et al.* (2019:2), Malatji and Madiba (2020:6,7) assert that uncaring behaviour leads to women feeling disrespected, neglected and profoundly humiliated, which threatens their sense of security and dignity. Uncaring behaviour can involve ignoring women's demands, a delay in receiving care, non-consented care and changing the topic when a woman is explaining her situation to a midwife, who thus fails to pick up possible problems during childbirth (Mårtensson *et al.*, 2020:1). Bradley *et al.* (2019:5) point out that women who experience uncaring behaviour in midwives are more likely not to trust them in future. Moreover, they may not follow midwives' advice and instructions if they have been treated unkindly, even to the point of being reluctant to report to the maternity unit for childbirth (Mårtensson *et al.*, 2020:1; John *et al.*, 2017:1; Henriksen *et al.* (2017:33).

Mayra, Matthews and Padmadas (2020:2); Bohren *et al.* (2019:7,8) and Sando *et al.*, (2017:2) describe uncaring behaviour in midwives during childbirth as follows:

- Physical abuse in the form of pinching, pushing, slapping and rough handling
- Verbal abuse in the form of harsh words and shouting
- Non-verbal abuse, such as ignoring a woman when she is talking, dismissing her concerns, making her wait a long time before being attended to, and not obtaining her consent for procedures, such as vaginal examinations, episiotomies, or perineal repairs.

This uncaring behaviour might be described as a failure to meet professional standards of care (Malatji & Madiba, 2020:6,8; Bowser & Hill, 2010:3-5) in caring for women during childbirth. Despite policies and government efforts to address uncaring behaviour during childbirth, women continue to complain that they are not being properly treated by midwives during childbirth in maternity units, which indicates a need for research into the behaviour of midwives in facility-based childbirth in different cultural and socio-economic settings.

John *et al.* (2020:166, 167) investigated women's experience of the uncaring behaviour of midwives during childbirth and found that 69.9% (n=58) reported

receiving caring maternity care, while 30.1% (n=25) experienced uncaring maternity care. Among the total number of women who experienced uncaring by midwives during childbirth, almost, all the respondents reported a lack of information about the progress of labour, a lack of privacy and verbal abuse such as scolding and shouting. Moreover, 92% (n=22) reported a lack of sensitivity towards women's pain and cultural identity and 6% (n=5) reported physical abuse in terms of being forcefully restrained and roughly handled.

Studies conducted by Bohren *et al.* (2019:7-8), Singh, Chhugani and James (2018:821); and Ogunlaja *et al.* (2017:7) showed that 71.2% (n=312) of the respondents had experienced one form of uncaring behaviour in midwives, such as physical abuse, verbal abuse, a lack of privacy and inadequate information about the progress of their labour. These results revealed that most labouring women experience uncaring behaviours on the part of midwives.

Henriksen *et al.*'s (2017:33) study found that of 1352 women sampled for the study, 21.1% (n=285) had had a negative birth experience. These results showed that the caring role of midwives during childbirth has been compromised. Similarly, Bohren *et al.* (2019:1) reported that more than a third of the women in their study experienced uncaring behaviour, which peaked 30 minutes before birth and lasted until 15 minutes afterwards. In addition, 35.4% of 2672 surveyed women (n=945) and 41% of 2016 observed women (n=838) experienced physical and verbal abuse. Moreover, 71.2% of 2016 women (n=1435) did not consent to a vaginal examination and 75.1% of 1680 women (n=190) did not give consent to an episiotomy. Of the women who experienced physical and verbal abuse, 49% to 59% (n=838) did not consent to a vaginal examination and 56% to 75.1% (n=1435) did not give consent to an episiotomy. As can be seen from the results, the uncaring behaviour of midwives leads to women's negative birth experiences.

Khreshheh *et al.* (2019:4), Bradley *et al.* (2019:2) and Bowser and Hill (2010:1) explored women's perceptions of midwives' behaviours during childbirth and found that uncaring behaviour during childbirth is still a global concern; despite the growing recognition of neglectful, abusive, and disrespectful treatment of women during childbirth in health facilities, which indicates a need to identify factors that prevent

caring behaviour in midwifery practice, affect the relationship between midwives and reduce the quality of care provided.

Lambert *et al.* (2018:257), Munabi-Babigumira *et al.* (2017:4-20) and Ndwiga *et al.* (2017:10) sought to identify factors that inhibit and facilitate the delivery of intrapartum and postpartum care in low- and middle-income countries (LMICs). These factors included a lack of an enabling working environment; inadequate resources and work overload/frustration/burnout due to a shortage of staff leading to long waiting times for women awaiting assistance. Moreover, there was a gap in the midwives' skills and knowledge due to a lack of professional development (Weldearegay *et al.*, 2020:2; Malatji & Madiba, 2020:6; Lappeman & Swartz, 2019:11). These factors are classified as the health system, structural, individual and midwives-/ women-related factors prevent midwives from meeting professional standards of care.

Malatji and Madiba (2020:6) and Munabi-Babigumira *et al.* (2017:4-20) indicate that even though midwives might be doing their best, they perform inadequately in a constrained environment where they do not feel motivated to meet professional standards of care, which affects the well-being and future birth choices of women. Henriksen *et al.* (2017:33) and John *et al.* (2017:1) maintain that women who have been exposed to uncaring behaviour tend to be reluctant to seek midwifery care at a previously visited unit and are prone to post-partum traumatic stress, which leads to a fear of giving birth.

Uncaring behaviour results due to a lack of time spent with the patient because of high workloads and pressure to finish a job override core midwifery competency and an increased number of complaints from women and significant others (Mårtensson *et al.*, 2020:2; Lohmann *et al.*, 2018:55). Bradley *et al.* (2019:3; Khresheh *et al.* (2019:76), Munabi-Babigumira *et al.* (2017:4-20) and Ndwiga *et al.* (2017:8-11) identify facilitating factors that influence the provision of caring behaviour during intrapartum and postpartum care in LMIC. The factors were in-service training and consistent selection of staff for professional development resulting in proficiency and an awareness of the appropriate clinical practice. Moreover, innovative caring behaviour is seen in midwives with advanced skills and development. Therefore, midwives need continuous upgrading for acquiring new skills and knowledge to advance their practical experience. In addition, John *et al.* (2020:168); Bohren *et al.* (2019:1756); Shallow,

Deery and Kirkham (2018:1) and Munabi-Babigumira *et al.* (2017:4) indicate factors facilitating midwives' ability to demonstrate caring behaviour during childbirth, such as adequate staffing; decreased workloads; teamwork, which facilitates collaboration and communication; the number of years' experience; and work satisfaction.

Little is known about the caring behaviour of midwives in Botswana, although Bamidele, Hoque and Van der Heever (2014:1) conducted a quantitative study to investigate the factors contributing to patients' satisfaction with the quality of care provided by healthcare providers, including midwives, in a primary healthcare setting in Botswana. The results revealed that out of a population of 360, only 8% of the respondents (n=27) were satisfied with the service provided by nurses and midwives, and 38% (n=135) were satisfied with the services of other care providers, as opposed to nurses and midwives. In other words, most of the respondents were not satisfied with the care provided to them by nurses and midwives.

Along with other studies, the above-mentioned research indicated the problem of uncaring behaviour in midwives, which needs further investigation. Therefore, motivated by the problem of uncaring midwives in some areas of the world, including Botswana (MoHW, 2011a), which leaves women feeling unwelcome, disappointed and frustrated the researcher embarked on a study of the caring behaviour of midwives in Botswana, aimed to identify and describe them and determine the factors that inhibit or facilitate the caring behaviour of midwives during childbirth.

### **1.3 Problem statement**

The researcher has been practicing as a professional advanced midwife in a maternity unit in one of Botswana's district hospitals for fourteen years. Over the years, she has heard complaints from labouring women about the way they were treated by midwives during childbirth. The women reported that midwives shouted at and spoke to them in harsh tones when giving instructions, used abusive language, and were impatient with and ignored them when they needed assistance, which led to some of them delivering without the presence of a midwife.

Uncaring of women by health professionals in maternity settings has been persistently reported at large in high, middle, and low-income settings (John *et al.*, 2020:166; Malatji and Madiba, 2020:6,8; Bradley *et al.* 2019:2; Ndwiga *et al.*, 2017:2), which is congruent with the observations made by the researcher. Uncaring behaviour includes



verbal and non-verbal, physical abuse, non-consented care, non-confidential care, abandonment, and the neglect of women in maternity units (Bohren. *et al.* 2019:7,8; Mukamurigo, Dencker & Berg, 2017:4; Bowser and Hill, 2010:3-5). Furthermore, as indicated above physical and verbal abuse can peak from 15 minutes before birth until 15 minutes' afterbirth. Moreover, the WHO (2015) released a statement that emphasised the abuse of women during childbirth in facility-based childbirth as a global phenomenon requiring urgent attention to ensure that every woman receives caring and dignified maternal care before, during and after childbirth.

Current guidelines on essential intrapartum care (WHO, 2015:1) and recommendations (WHO, 2018:200) for the prevention and elimination of uncaring behaviour during childbirth were consolidated to allow every woman the right and access to skilled maternal healthcare providers. Yet women's expectations continued to be compromised by uncaring behaviour from midwives during childbirth in maternity units in the form of physical abuse such as pinching, pushing, slapping, rough touching and verbal abuse (harsh language) and non-verbal abuse like ignoring and not responding to women's requests (Mayra *et al.* 2020:2; Malatji & Madiba, 2020: 6,7; Sando *et al.* 2017:2). These experiences leave women feeling disrespected, neglected and profoundly humiliated.

In Botswana, in all public maternity facilities, there is a formal complaint procedure for women to follow, which has led to reports of the uncaring behaviour of midwives. However, there is no literature on the uncaring behaviour of midwives in Botswana. Therefore, the current study aimed to identify and describe the caring behaviour of midwives who nurse women during childbirth in Botswana.

#### **1.4 Research questions**

The above-mentioned problem indicates that women are not satisfied with the care received from midwives. Therefore, the study sought to answer the following research questions:

- What are the caring behaviours of midwives in Botswana?
- What are the factors that inhibit the caring behaviour of midwives in Botswana?
- What could be done to optimise the caring behaviour of midwives in Botswana?

## **1.5 Research objectives**

In line with the research questions, the following research objectives were formulated:

- To identify and describe the caring behaviours of midwives in Botswana
- To determine the factors that inhibit the caring behaviour of midwives in Botswana
- To make recommendations for midwives and unit managers that could be used to optimise the caring behaviour of midwives in Botswana

## **1.6 Significance of the study**

The study was significant because midwives and unit managers might use the recommendations based on the findings to optimise the caring behaviours of midwives when nursing women during childbirth in Botswana. The study's findings might inform researchers, professionals and policymakers about the caring behaviour of midwives in Botswana and the factors that inhibit or facilitate it. Thus, the study might contribute to policymakers making informed decisions when amending midwifery programmes.

## **1.7 Clarification of concepts**

Polit and Beck (2018:398) and Grove, Burns & Gray (2018:134) maintain that a concept describes a phenomenon being studied by indicating its distinct identity. The key concepts of the study are clarified in the following sections.

### **1.7.1 Caring behaviour**

Caring behaviour is described as a nurturing way of relating to a valued other to whom one feels a personal sense of commitment and responsibility (Mårtensson *et al.*, 2020:1124; Kalfoss & Owe, 2015:997; Swanson, 1991:164). Caring is knowing, understanding, and conveying an emotional affinity with another that includes kindness and respect (Khresheh *et al.*, 2019:1). Caring behaviour in the study referred to a midwife's act of being with and for a woman whilst continuously conveying respect and preserving her dignity in a calm, safe environment throughout the childbirth process.

### **1.7.2 Childbirth**

Childbirth is a multidimensional process of giving birth to or delivering a baby, which is accompanied by regular, uncontrolled and vigorous labour pains, stress, sadness, happiness and joy experienced together during which a woman tends to exhibit anxiety, restlessness and an inability to cope with the discomfort as the neurohormonal reaction increases (Aktaş & Aydin, 2019:176; Henriksen *et al.*, 2017:17). In the study, childbirth referred to the period when a woman is giving birth in a maternity unit under the care of a midwife.

### **1.7.3 Maternity unit**

A maternity unit is described as a specialised public or private institutional structure functionally embedded within the healthcare system, designed for caring for all childbearing women and infants within the framework for the provision of 24-hour maternal and new-born care, undergirded by skilled-health professionals to provide holistic care to every woman during childbirth (WHO, 2018; Lohmann *et al.*, 2018:53; DoH, 2015:19). A maternity unit in the study referred to a 24-hour maternal health care unit in Botswana, run by midwives providing the necessary care and support to women during childbirth.

### **1.7.4 Midwife**

A midwife is a person of either gender who has completed a midwifery programme which is recognised in the country where it is located and has acquired the requisite qualification to be registered and/or legally licensed to practise midwifery (ICM, 2018:1; Republic of Botswana, 1995:66). In addition, a midwife is a person recognised as a responsible, trustworthy and independent practitioner, who works in partnership with a woman whilst giving the necessary support, care and advice during childbirth. In the context of the study, a midwife means a person who is responsible to provide care and facilitating births in a maternity unit or ward setting, is licensed to practise midwifery and is registered with the Nursing and Midwifery Council of Botswana.

### **1.7.5 Woman**

The term “woman” designates an adult human female, who is legally entitled to receive midwifery care during pregnancy, labour, childbirth, the post-partum period and until the weaning period (Lohmann *et al.*, 2018:54; Dzomeku, Van Wyk, Knight & Lori, 2018:3). Women in this study means the female persons cared for by midwives during childbirth in a maternity unit, in Botswana.

## **1.8 Theoretical framework**

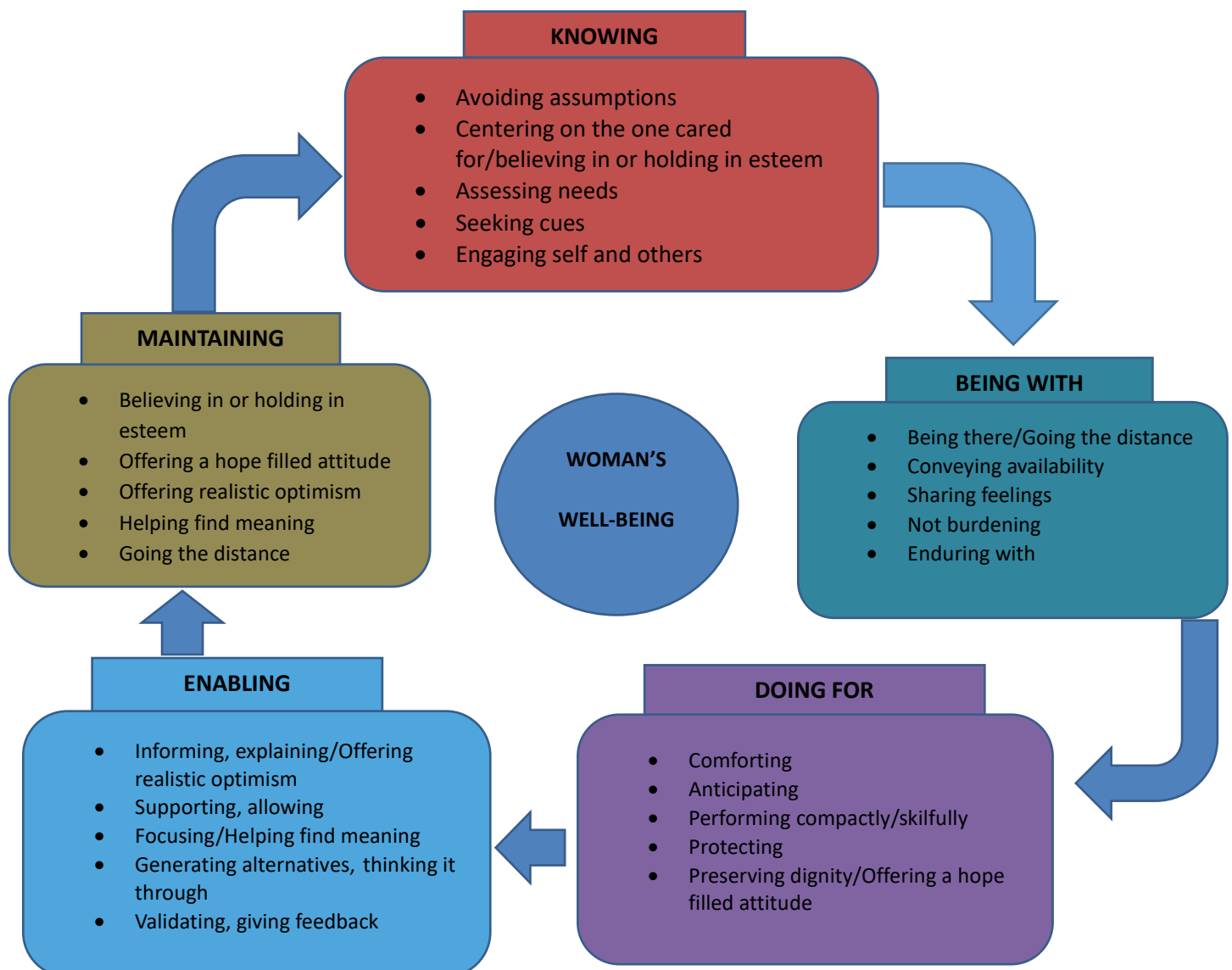
A theoretical framework is a logical structure of related ideas that serves as a lens or guide for the development of knowledge in research (Moule, Aveyard & Goodman, 2017:123). In addition, it should be directly relevant to the topic of research, explain reality or be speculative (Master, 2015:319). A theory summarises and organises the current understanding of a phenomenon and is systematically tested in research (Djukic *et al.*, 2018:156; Smith & Parker, 2015:7).

The theoretical framework underpinning the study was Swanson’s (1991) Theory of Caring, which originated in Washington, the United States (US). The general or broad theory of human caring theory was developed by Watson in the 1970s, which was followed in 1991, by Swanson’s middle-range (limited in scope) Theory of Caring, consisting of five caring processes: maintaining belief; knowing; being with; doing for; and enabling (Swanson, 1991). Swanson modified the caring theory to include notions of recipients achieving well-being (1993), counselling interventions (1999a) and meta-analysis in caring research (1999b).

Swanson’s (1991) Theory of Caring was developed and used as a guide for clinical practice in intensive care units (Kalfoss & Owe, 2015:1; Smith *et al.*, 2013:211). The theory aimed to help practitioners deliver nursing care that focuses on the needs of patients whilst fostering respect and kindness as well as patients’ dignity, comfort, empowerment and autonomy. The theory was later adapted and applied in nursing and midwifery practice and research with the intended outcome of a woman’s well-being (Mårtensson *et al.*, 2020:1123; Khresheh *et al.*, 2019:3; Kalfoss & Cand, 2016:996)

In nursing research, Swanson’s (1991) theory conceptualises a meaning of caring that goes beyond nurse-woman dynamics (Swanson, 1993; 1999b) and implies consistent caring behaviour, which improves a woman’s satisfaction. Swanson’s (1991) theory

and conceptualisation of caring underpin several studies on caring behaviour during childbirth (Mårtensson *et al.*, 2020:1122; Khresheh *et al.*, 2019:3). The theory informs and improves the caring behaviour of midwives working in maternity units with the intended outcome of enhancing women's satisfaction during childbirth (Khresheh & Barclay, 2019:71). The theory was considered appropriate for the current study because it focuses on the importance of midwives being mindful of the needs and well-being of labouring women and its conceptualisation of five caring processes (Mårtensson *et al.*, 2020:1). Moreover, the theory was expected to guide recommendations once the results of the data analysis had been interpreted. The structure of Swanson's (1991) five caring processes is illustrated in Figure 1.1 below.



**Figure 1.1: Swanson's five caring processes**

*Adapted from Swanson (1991:161-164)*

### **1.8.1 *Knowing***

According to Swanson (1991:163), knowing refers to an individual striving to perceive events according to the meaning they have to another person. In other words, it is a humanistic view of nurturing and understanding another's situation (Swanson, 1993). In the context of midwifery, knowing involves a thorough assessment of all the aspects of a woman's condition and creates a bond between a midwife and a woman, which enables the midwife to fulfil the woman's needs during childbirth. When midwives know and understand the women, they will be able to provide them with the holistic care required during childbirth, thereby recognising them as significant beings.

### **1.8.2 *Being with***

Being with is being emotionally and physically present for another (Swanson, 1991:163). It involves giving time to another through an authentic presence, attentive listening and reflective responses (Swanson, 1993). In other words, "being with" is the progressive availability of a midwife for the woman during childbirth; sharing feelings, power and responsibility; showing kindness, respect and support as a result the woman feels comfortable and valued.

### **1.8.3 *Doing for***

Doing for refers to undertaking an activity for others that they would do for themselves if they were able (Swanson, 1991:164; 1993). In other words, a midwife performs actions that a labouring woman would do for herself if possible. These actions could be comforting women, anticipating their needs, performing procedures skilfully, protecting them from harm and ultimately preserving their human dignity (Swanson, 1999c). In terms of a midwife, "doing for" means providing skilful care while maintaining the woman's dignity; honouring and respecting her and facilitating her self-healing and hope.

### **1.8.4 *Enabling***

Enabling means facilitating another's passage through life's transitions and events, which are unfamiliar to her (Swanson, 1991:164; 1999b). In the context of a midwife, the process of enabling involves providing labouring women with clear information, guidance, instructions, advice and support during the painful experience of childbirth, which foster motivation and determination to cope with the event (Swanson, 1993).

Enabling means that the midwife is empowering a woman to handle childbirth, develop self-care and have a positive birthing experience.

### **1.8.5 Maintaining belief**

The last caring process refers to upholding faith in another's ability to cope with a difficult experience and face the future with hope by showing positivity, confidence and trust in her strength to handle the situation (Swanson, 1993; 1991:165). In the context of a midwife, "maintaining belief" means conveying a sense of hope and trust in the labouring woman so that she can feel confident that she will get through the childbirth process effectively.

## **1.9 Research design and methods**

A research design is a clear plan according to which a study will be conducted to answer the research questions and attain the research objectives (Polit & Beck, 2018:51; Holloway & Galvin, 2016:125). A study's research design guides the methods used to select a sample, select the data-gathering instruments, gather information and analyse the data. An overview of the research design and methods will be provided in this section, but the detail will be presented in Chapter 3.

### **1.9.1 Research design**

As stated above, a research design is a plan or blueprint that outlines how the chosen methods will be implemented and the specifications for enhancing the study's integrity (Moule *et al.*, 2017:151; Gray, Grove & Sutherland, 2017:52). Furthermore, the previous authors, described that research design determines the technique for selecting samples, collecting data and how the data would be analysed. A quantitative, descriptive design was followed in the study to identify and describe the caring behaviour of midwives who nurse women during childbirth. A detailed description of the research design is found in Chapter 3 of this dissertation.

#### **1.9.1.1 Quantitative research design**

A quantitative research design indicates gathering data in the form of numbers (Polit & Beck, 2018:415; Fain, 2017:155). It is implemented by using quantitative methods that follow a formal, objective and systematic process to obtain data, which are statistically analysed (Gray *et al.*, 2017:349; Fain, 2017:155) to generate results, the

interpretation of which, in the current study, would lead to conclusions about the caring behaviour of midwives who nurse women during childbirth.

#### **1.9.1.2 Descriptive research design**

A descriptive research design is a plan for describing a phenomenon of interest in a real-life situation (Polit & Beck, 2018:400; Gray *et al.*, 2017:39; Fain, 2017:264). In other words, a descriptive research design was used to identify shortcomings within the current study, and determine what others are doing in a similar situation (Polit & Beck, 2018:400). In the current study, the descriptive research design determined the use of research methods that were appropriate to obtain information to describe the phenomenon of caring behaviour of midwives in Botswana.

### **1.9.2 Research methods**

Research methods are specific procedures followed in conducting a study (Polit & Beck, 2018:400; Moule *et al.*, 2017:34). They described the methods, techniques and procedures that are employed in the process of implementing the research plan (Grove & Gray, 2019:228). The following sub-sections describe the methods used in the study for determining the population, study setting, and obtaining the necessary sample. In addition, the data collection process, data collection instrument, pilot study, data analysis and ethical considerations were explained.

#### **1.9.2.1 Population**

According to Jooste (2018:334) and Moule *et al.* (2017:165), a research population is the whole group of people whom the researcher is interested in gathering data. In other words, a population consists of the entire group of people or elements that represents the focus of the research (Grove *et al.*, 2017:53). In the study, the research population included all midwives who care for women during childbirth in Botswana.

#### **1.9.2.2 Study setting selection**

Gray *et al.* (2017:352) and Fain (2017:151) describe a study setting as the location where a study is conducted or carried out. The study was conducted in Botswana in three districts which were purposively selected as representative of the different levels of health care delivery, which included referral hospitals, district hospitals and clinics with maternity units. Moreover, they were the main Regional Health Management



Teams in the region where the researcher worked. Therefore, the study site comprised maternity units in the Kgatleng and Greater Gaborone health districts in the South-East District of Botswana.

#### *1.9.2.3 Target and accessible population*

Jooste (2018:334) and Moule *et al.* (2017:165) define a target population as an aggregation of a group of people about whom the researcher is interested in finding information, who meet specific criteria for the study and allow the researcher to make generalisations and assumptions about the general population. In addition, the above-mentioned authors maintain that a target population is a subset of a group of people accessible to the researcher from which a researcher draws a sample of the composition which shares a common set of traits relevant to the study. Grove and Gray (2019:228) describe an accessible population as the section of the population to which a researcher has reachable access and from which a sample can be drawn.

The target population for the study was all professional midwives working in the maternity units of the Kgatleng and Greater Gaborone District Health Management Teams (DHMTs) who met the inclusion and exclusion criteria for participating in the study. The researcher chose the target population by making sure that its composition met the specific criteria for the study and that its members shared a common set of traits. The target population for the study comprised 250 professional midwives.

#### *1.9.2.4 Sampling*

According to Polit and Beck (2018:413) and Jooste (2018:335), sampling is a technique used for selecting respondents from the target population to ensure that they are representative of it and the total population for the study. The researcher, based on the criteria mentioned above, used a non-probability, purposive sampling technique in this study. In the study, a purposive sampling technique was used for selecting professional midwives who met the specific inclusion and exclusion criteria of the study. A purposive sampling technique was used for selecting the sample because it was quick, simple and economical.

#### *1.9.2.5 Sample*

A sample is defined as a subset of the target population, which is selected for participation in a study and is representative of it (Polit & Beck, 2018:417; Fain,

2017:135). The sample for the study was selected from the professional midwives working in the maternity units of Kgatleng and Greater Gaborone Health Districts in Botswana.

#### *1.9.2.6 Sample size*

Polit and Beck (2018:417) and Moule *et al.* (2017:167) maintain that the sample size is the specified number of respondents included in a research study. The above-mentioned authors further defined a sample size as a certain percentage of the target population selected to represent the entire population. A total of 200 professional midwives working in maternity units, who met the inclusion criteria, participated in the study.

#### *1.9.2.7 Data collection*

Data collection is the formal process of acquiring data from study respondents according to a standardised method (Polit & Beck 2018:201; Fain, 2017:315). The data collection used in the study was a self-administered, survey questionnaire.

After obtaining ethical approval letter number (H20-HEA-NUR-010) from the Nelson Mandela University (NMU) Research Ethics Committee: (REC-H) (see Annexure A), and the Ministry of Health and Wellness in Botswana (see Annexures D to F). The researcher, thereafter, followed the process for recruiting the respondents for the study, such as initially linking up with unit managers through personal appointments and face-to-face contacts, to build rapport and trust with them, and have them assist in reaching out to the potential respondents (Polit & Beck, 2018:54; Jooste, 2018:309; Gray *et al.*, 2017:54).

Unit managers assisted the researcher in arranging the appropriate time for respondents in meeting with them at their convenient working shifts. The researcher, therefore, had to reach out to the respondents at their various working places and at their convenient times. Written, informed consent was obtained from each respondent who voluntarily participated in the study (see Annexure G for an example of the consent forms).

Data collection was conducted between March and May 2021 from 200 respondents, who willingly participated in the study. This process, unfortunately, took much time because the study was carried out during the coronavirus disease 2019 (COVID-19)

pandemic level-3 lockdown in Botswana, which restricted people's movement and overcrowding at workplaces. In addition, face-to-face engagement was minimal, because respondents were working as skeletal staff, and it was not easy to always reach out to the potential respondents. Moreover, the researcher adhered to the COVID-19 regulations and guidelines as required (MoHW, 2020; Tremblay *et al.*, 2021:2).

#### **1.9.2.8      *Data collection instrument***

A data collection instrument is a formally designed device used to collect data (Polit & Beck, 2018:406; Fain, 2017:215). A structured, self-administered questionnaire was the data collection instrument used in the study, which was developed by the researcher based on the literature review. The questionnaire was used to collect quantitative data from the sample of midwives in maternity units in the Kgatleng and Greater Gaborone Health Districts in Botswana to answer the research questions and meet the research objectives.

The questionnaire was prepared in English because all respondents were fluent in this language, and there was no need for a language translator. The questions were constructed in such a way that they were easy to understand, thereby ensuring that all the respondents interpreted the questions the same way (see Annexure H).

### **1.10    Data analysis**

According to Moule *et al.* (2017:346) and Fain (2017:265) data analysis is the process of describing, organising, and summarising data to obtain answers to the research questions. The researcher checked the completed questionnaires for possible questions incorrectly answered or left out before the data were captured on Microsoft Excel® spreadsheets. The researcher analysed the data with the assistance of a Nelson Mandela University statistician, which led to the generation of descriptive and inferential statistics, which would be employed to generalise the results to an equivalent population (Harvey & Land, 2017:169). Statistical analysis enables a researcher to summarise, organise, interpret and communicate quantitative data.

Chapter 3 will provide a more detailed discussion of the data analysis. The results of the data analysis will be presented, in the form of tables and charts in Chapter 4 of this

dissertation, which will be interpreted and discussed in terms of Swanson's (1991) Theory of Caring, the research questions and the research objectives.

### **1.11 Pilot study**

A pilot study is a small-scale trial run of a study, using a small sample that is representative of the target population to test a data collection instrument for reliability and validity (Moule *et al.*, 2017:339). Whitehead *et al.* (2016:1057,1071) suggest that a pilot study sample size should be 10 to 40 respondents or 10% of the larger sample used in the study. The pilot study was conducted with 10 midwives drawn from the target population to make sure that the questions asked were clear and effectively solicited the desired information. The results of the pilot study were not included with those of the main study, and no adjustments were made to the questionnaire, which was thus used for data collection.

### **1.12 Reliability and validity**

Reliability is the level of consistency and uniformity with which a data collection instrument measures what is intended to measure and can obtain the same results every time it is used under the same conditions by different researchers or agents (Moule *et al.*, 2017:184; Gray *et al.*, 2017:690). Moreover, Fain (2017:250) and Harvey and Lan (2017:292) refer to validity as the ability of the instrument to measure accurately what it is supposed to measure. Validity is enhanced through the application of face and content validity.

Content validity is the evaluation of an instrument to ensure that it covers the complete content of the construct that it is supposed to measure. Face validity refers to whether a research instrument appears to measure what is supposed to measure. To determine the reliability and validity of the questionnaire, a pilot study was carried out to rule out uncertain items (Fain, 2017:245). In addition, as recommended by Harvey and Lan (2017:292) and Gray *et al.* (2017:410), the researcher ensured that the questionnaire was reviewed and evaluated by the supervisors, a statistician and reviewers from the Research Ethics Committee of Nelson Mandela University to confirm that all the characteristics of the variables were included in the questions.

### **1.13 Ethical considerations**

Ethical considerations are the accepted standards of behaviour and procedures that researchers are obliged to follow when conducting human research, as outlined in the National Health Research Ethics Council for the Protection of Human Subjects of Biomedical and Behavioural Research (DoH, 2015). Moreover, in the study, the researcher adhered to the ethical principles of the Belmont Report of 1979 (DoH, 2015), as explained below.

#### **1.13.1 Informed consent**

Informed consent is a respondents' voluntary agreement to participate in a study about which they had been given the necessary information (Polit & Beck, 2018:406). A brief overview of the study was presented to the respondents so that they could make an informed choice about whether to participate in the study. A respondent's information document was given to the respondents to read and sign to ensure that they understood what they were required to do in the study (see Annexure G). In addition, the respondents were requested to write their names in the consent letter, but they were not allowed to write their names on the questionnaire to ensure anonymity and confidentiality. These two documents were kept separately.

#### **1.13.2 Respect for persons**

Respect for persons means that individuals should be treated as autonomous agents (Gray *et al.*, 2017:163), and due regard should be given to their opinions and choices in response to the information provided. The respondents were provided with an information letter and informed consent form (see Annexure G). They were informed not to write their names on the questionnaire to ensure anonymity. Furthermore, they were informed of their right to participate or withdraw from the study at any time without penalty.

#### **1.13.3 Privacy, anonymity and confidentiality**

According to Polit and Beck (2018:79, 81) and Jooste (2018:310), privacy, anonymity and confidentiality protect a respondent's identity and information about him or her from unauthorised access and disclosure. Privacy, anonymity and confidentiality are assured by keeping respondents' names and information safe. Therefore, in the study, the responses to the questionnaires were identified by the respondents' numbers, as

opposed to their names, thereby ensuring that nothing linked the respondent's information with their identity. The researcher made it clear to the respondents that only the researcher, supervisors and the statistician had access to the questionnaires that had been completed.

#### **1.13.4 Beneficence**

The principle of beneficence means that the researcher must not expose respondents to harm or discomfort, thereby protecting and securing their wellbeing and comfort (Polit & Beck, 2018:79). According to the National Health Research Ethics Council for the Protection of Human Subjects of Biomedical and Behavioural Research (DoH, 2015:54), harm is defined as anything that negatively hurts a respondent's welfare either emotionally or socially. The researcher ensured that data collection took place at a time that was convenient for respondents. Moreover, in the study, respondents were informed that there were no foreseeable risks and discomfort associated with the study. They were given the right to withdraw from the study at any time they felt uncomfortable without penalty, although none of the respondents withdrew from the study.

#### **1.14 Dissemination of results**

The dissemination of results is the communication of research outcomes to others, such as midwives and other health professionals in the context of a study (Fain, 2017:302; Moule *et al.*, 2017:382). The electronic version of this dissertation will be made accessible through the Nelson Mandela University library for public use and sent to the Human Research Development Division (HRDD) in Botswana.

An article will be prepared for publication in a peer-reviewed academic journal. Furthermore, the researcher will respect the respondents' right to be informed about the research results (Jooste, 2018:313) by conducting at least one feedback session for them in a form of workshops, in-service training, lectures or nursing and midwifery conferences and symposiums. These sessions will be provided to ensure that all the individuals and facilities that participated in the study obtain the research results.

### 1.15 Chapter layout

This dissertation will consist of six chapters, as illustrated in Table 1:1 below.

**Table 1.1: Layout of the research study**

Chapters	Content
1	Overview of the study
2	Literature review
3	Research design and methods
4	Data analysis, interpretation and discussion of the results
5	Design and development of recommendations
6	Summary, conclusions, limitations and recommendations

### 1.16 Summary of the chapter

This chapter gave an overview of the study by presenting the background; the problem statement that led to the research study; the research questions and objectives; the theoretical framework underpinning the study; and the research design and methods, which included sampling, data collection and analysis. Determining the reliability and the validity of the study, ethical considerations and the dissemination of the research outcomes were also discussed. The following chapter is a review of the literature on the topic of the study.

## CHAPTER 2

### LITERATURE REVIEW

#### 2.1 Introduction

An overview of the study was presented in the previous chapter. This chapter reviews the literature on the caring behaviour of midwives and the factors that facilitate or inhibit it. In addition, the purpose of a literature review is to explore current and sufficiently relevant literature, upon which a study has been built, and to establish familiarity with, and understanding of, current research in a particular field before reporting the investigation. A literature review indicates what is known or unknown about a topic and the gap in knowledge that a researcher will fill to contribute to further understanding (Maree, 2016:28).

This literature review is presented under the following headings: the concept of caring behaviour; theoretical perspectives of caring behaviour; caring behaviour as a core aspect of midwifery practice; caring behaviour as viewed by midwives; women's expectations of caring behaviour during childbirth; evidence of uncaring behaviour of midwives during childbirth; implications of uncaring behaviour during childbirth; standards of midwifery practice; and an overview of the health system in Botswana.

#### 2.2 The concept of caring behaviour

Caring behaviour is a globally recognised concept (Joh *et al.*, 2019:2; Bohren *et al.* 2019:2; WHO, 2018b), although it is explained in many ways and involves various approaches within different contexts. Kalfoss and Cand (2016:966) describe caring behaviour as feeling or showing concern for others and moral and interpersonal sensitivity, which leads to emotional support, kindness and meeting the psychosocial needs of another person.

Maharma *et al.* (2021:6), Larsson and Hill (2018:810) and Watson (2008) mention that caring behaviour requires personal, social and spiritual engagement as well as a commitment to other human beings. In addition, Sebrant and Jong (2021:354); Dahlberg (2019:27) and Watson (2008) maintain that caring behaviour is a science that encompasses an interpersonal interaction between a midwife and a labouring woman. This means that a relationship of trust and willingness should be established



between midwives and labouring women who are shown respect and kindness throughout the childbirth process. Moreover, the concept of caring behaviour can be explained by various theories of caring followed in nursing education, practice and research.

### **2.3 Theoretical perspectives of caring behaviour**

The science of caring comprises a cluster of precisely selected beliefs and values crafted into theoretical structures (Watson, 2008). Caring behaviour in healthcare encompasses the ethics of restoring, healing and love (Turkel, Watson & Giovannoni, 2018:66-67). Turkel *et al.* (2018) view caring behaviour as essential to ensuring human dignity. Sebrant and Jong (2021:354) and Khresheh *et al.* (2019:1) describe caring as a human trait and a moral principle that lead to an obligation of caring for others.

Mestdagh, Timmermans and Rompaey (2019:6), Larsson and Hill (2018:816) and Cherry (2018:1,2) maintain that caring depends on a person's conscience, which shapes and guides his/her behaviour, which drives him/her to show respect and value the dignity of others. Thus, caring behaviour demonstrates love, compassion and willingness to care for women during childbirth and promotes a positive relationship between them and their midwives.

Theories of caring, which, when integrated into clinical practice, promote a harmonious, healing environment that preserves human dignity (Al-Maharma *et al.*, 2021:2; Mårtensson. 2020:1125). Therefore, in this section of the dissertation, a few caring theories are described and compared in terms of meaning, the constructs of caring, and how they are applied in nursing research. Moreover, Watson's, Eriksson's and Swanson's theoretical structures have been established as core to the concept of human caring in different healthcare settings and healthcare providers. The theories are discussed below to contribute to an understanding of the quality care required of midwives.

#### **2.3.1 Watson's (2008) Theory of Caring**

Watson's (2008) Theory of Caring is defined as the moral ideal of nursing whereby the end is the protection, enhancement and preservation of human dignity. Watson's theory is used as a guide in human caring that embraces human dignity in childbirth settings (Al-Maharma *et al.*, 2021:2; Khresheh *et al.*, 2019:70). Watson's (2008) theory

places special emphasis on caring and love that potentiate healing, and health sciences would not be complete without this theory. Moreover, caring leads to interpersonal interaction that encourages emotional attachment and dependency. Watson (2008) believes that caring involves an expression of openness, receptiveness and authenticity within a personal context. In addition, the labouring woman's belief and trust are enhanced by the caring behaviour of the midwives, with them becoming devoted to each other. Watson (2008) views caring as a therapeutic intervention and a deliberate act with a planned goal in mind, which lead to a commitment and spiritual engagement, thereby enabling a delivering woman to feel honoured, determined and hopeful.

### **2.3.2 Eriksson's (2002) Theory of Caring**

Eriksson's (2002) Theory of Caring describes caring as a fundamental understanding of human nature (Cherry 2018:1-2). The theory emphasises a holistic image of a human being in which the different dimensions of the body, soul and spirit are integrated (Larsson & Hill, 2018:810). Eriksson's (2002) theory elaborates that health encompasses more than just physical well-being; rather, there is coordination between the body, the soul and the spirit, which replaces despair with emotional and physical integrity versus despair. In other words, when a labouring woman is treated with respect and human dignity, she feels proud and can give birth to her child with pride and in control of her mind, emotions and body. On the contrary, when her expectations are not met during childbirth, she is left with the feeling of bitterness, regret and despair.

### **2.3.3 Swanson's (1991) Theory of Caring**

Swanson's (1991) Theory of Caring was developed to help practitioners deliver nursing care that specifically focusses on people's needs in a way that fosters dignity, respect, kindness, comfort and empowerment (Mårtensson *et al.*, 2020:1123; Khresheh & Barclay, 2019:70; Lohmann *et al.*, 2018:58). The theory emphasises five caring processes, which encapsulate ethics and the patient's dignity (Kalfoss & Cand 2016:996): knowing; being with; doing for; enabling; and maintaining belief. These caring processes cultivate meaningful, healthy relationships between the midwives and the labouring women. Swanson's (1991) Theory of Caring indicates that when

midwives display caring behaviour, they make labouring women feel safe, comfortable and able to face the childbirth process with faith and hope (Swanson 1991, 1993).

Swanson's (1991) perspective of caring behaviour is like that of Watson's (2008) and Eriksson's (2002), as it is characterised by love and compassion. According to Al-Maharma *et al.* (2021:6) and Larsson and Hill (2018:810), Swanson's (1991) theory reveals that health encompasses more than just physical well-being and involves a holistic interaction between body, soul and spirit. As a result, midwives ought to be continually, physically and emotionally present to show kindness, respect and support when caring for women during childbirth.

## **2.4 Caring behaviour as a core aspect of midwifery care**

Caring behaviour is a central pillar of midwifery, as it involves midwives showing respect, kindness and empathy towards labouring women, which facilitates positive childbirth outcomes (Al-Maharma *et al.*, 2021:1; Mårtensson *et al.*, 2020:1123; Khresheh *et al.*, 2019:1). Moreover, studies have found that effective caring promotes healing, a sense of wholeness and inner peace that transcend fear during the intrapartum period. Integrating women's spirituality in midwives caring behaviour can convey and sustain caring for women during childbirth because they genuinely feel accepted for who they are as a person (Mårtensson *et al.*, 2020:1131). Moreover, Watson's (2008), Swanson's (1991, 1999b) and Eriksson's (2002) caring theories emphasise that the caring behaviour of midwives embraces supporting and helping labouring women to achieve harmony of mind, body and soul as well as inner peace. It is the art of making them feel special and in touch with their inner feelings, thereby promoting and providing feelings of safety, strength and courage during the labour process (Larsson & Hill, 2018:812).

Khresheh *et al.* (2019:3), Maputle (2018:2) and Swanson (1991) point out that the constant availability of midwives offering support, information and other forms of tangible assistance enables women to cope with stress. As a result, midwives alleviate their anxiety and make them feel comfortable, which increases their satisfaction and creates a positive birth experience. Larsson and Hill (2018:812) indicate three characteristics of caring behaviour, which are core to midwifery: women-centred care; midwifery values; and professional skills and knowledge, which are unpacked below.

#### **2.4.1 Women-centred care**

Mayra, Matthews and Padmadas (2021:8); Al-Maharma *et al* (2021:1); Brodie, Sandal and Leap (2019:737) and Dzomeku *et al.* (2018:3) describe women-centred care as a distinctive, imperative characteristic of midwifery. It involves meeting the women's expectations of care, understanding what good quality care is to them, ensuring a positive birthing experience and allowing delivering women to make their own choices and control the relationship between them and the midwives. A midwives' priority, therefore, is to put the needs, expectations and demands of the women first (Larsson & Hill, 2018:812-814).

The ICM (2018:8-18) provides systematic guidelines for woman-centred care and emphasised recommendations to improve the standard of maternal service delivery (Maputle, 2018:10). These principles envision midwives as advocates for women's right to quality maternal care and indicate that midwives should allow women equal access to personal control and decision making and be given full and accurate information about the childbirth process. This includes standing against the abuse of women during childbirth and gaining women's trust.

Anderson *et al.* (2020:6) and Fontein-Kuipers, de Groot and Van Staa (2018:1-3) are in support of woman-centred care when they point out that the focus should be on the collaboration between the midwife and the woman in labour whose needs are clearly understood. In addition, they should work together towards a common goal, share responsibility and both be involved in making informed decisions. Continued communication and psychological support during childbirth are considered the utmost in women-centred care. Homer, Brodie, Sandal and Leap (2019:737) and Kalfoss (2016:996) emphasise that woman-centred care is the lifestyle commitment, that encourages midwives to be available for the labouring women with focus on their beliefs and values that underpin midwives caring behaviour actions during childbirth.

#### **2.4.2 Midwifery values**

Midwifery values are described as fundamental beliefs that guide or motivate midwives to act one way or another (ICM, 2019:8-18, 2022:3; Larsson & Hill, 2018:812-814). Mestdagh *et al.* (2019:2) maintain that midwifery values involve respect, trust, open-mindedness, commitment, discipline and responsibility, which are prerequisites for practice. Khresheh *et al.* (2019:1) and Larsson and Hill (2018:814), emphasise that

midwives should act with a redemptive spirit and calm mind to establish a close trusting relationship that alleviates anxiety, as opposed to providing randomly fragmented care. Therefore, midwives must always be courageous and recognise labouring women as human beings. Malatji and Madiba (2020:10) and Ndwiga *et al.* (2017:11-12) observe that every woman has a right to be respected as a person of value and worth.

Moreover, recent studies on the caring behaviour of midwives during childbirth (Anderson *et al.*, 2021:14; Al-Maharma *et al.*, 2021:2; Mårtensson *et al.*, 2020:1128; Khresheh & Barclay, 2019:73) point out that a caring midwife would continuously be with the labouring woman, providing physical and emotional support. Kwaleyela, Greatrex-White and Denis's (2019:1602) study of midwives in Zambia emphasises the core value "being with", which is part of caring behaviour and requires a midwife to use an empathetic tone of voice when giving instructions to a labouring woman because it establishes a close interpersonal relationship and promotes autonomy. Moobs, Williams and Weeks (2018:1-2) note that the language used by a midwife is key to effective communication during childbirth and encourages the labouring woman to participate actively in making decisions about her healthcare. Effective communication during childbirth is also a prerequisite and a common standard towards midwives' professional skills and knowledge in midwifery practice (Beek McFadden & Dawson, 2015:5; ICM, 2018:8-18; Larsson & Hill 2018:814).

### **2.4.3 Professional skills and knowledge**

The ICM (2018:8-18) in its document entitled *Essential Competencies for Midwifery Practice Guidelines* outlines the competencies for midwives, which include the knowledge and skills required for registration as a midwife. Beek *et al.* (2019:5) discussed the Global Standards of Professional Midwifery and point out that professional midwives should be able to work independently and responsibly in performing their roles of caring for women during childbirth. Anderson *et al.* (2020:7); Khresheh *et al.* (2019:2) and Larsson and Hill (2018:812) remark that skilled midwives should have good listening and communication skills when working with the labouring women, serving them in an unbiased and empathetic manner; whilst respecting their concerns and points of view. In other words, midwives need communication and language skills so that the women would be able to understand them whilst sharing information during childbirth.

Larsson and Hill (2018:812) maintain that midwives' knowledge and skills are improved by the level of their commitment to serving the women during childbirth (Anderson *et al.*, 2020:7). The ICM (2018:1), Munabi-Babigumira *et al.* (2017:4-20) claim that professional development empowers midwives to enhance their knowledge, skills, competencies, confidence and morale, thereby ensuring caring behaviour. Lambert *et al.* (2018:41) argue that inadequate on-the-job training and inconsistent staff development mean that midwives do not keep up-to-date with knowledge and skills, which compromises their ability to deliver quality care.

## **2.5 Caring behaviour as viewed by midwives**

Midwives understand that they should demonstrate caring behaviour towards women during childbirth because they have taken a pledge to ensure their total health (International Code of Ethics for Midwives, 2014:1-3). The ICM (2018:3-5) and the Global Standards for Midwifery Education (ICM), 2018:6) emphasise that caring for others is a major aspect of midwifery practice, which determines the profession's status and integrity. According to Mestdagh *et al.* (2019:1), Lohmann *et al.* (2018:58); and Ndwiga *et al.* (2017:8) midwives are aware that they are obliged to recognise labouring women as significant beings, facilitate the relationship of trust whereby the balance of power between them and the women is established through mutual agreement and shared responsibility regardless of clinical complexity and unfavourable work environments. Moreover, Weldearegay *et al.* (2020:18) and Mestdagh *et al.* (2019:1) find that caring behaviour enhances a positive birthing experience, job satisfaction, efficiency, commitment, coping mechanisms and stress resilience.

El-Alti, Sandman and Munthe (2019:49) and Dzomeku *et al.* (2018:7) maintain that interaction between a healthcare professional and the woman involves becoming familiar through their narratives, shared understanding of the intended outcomes of procedures and collaborative decision-making during the caring period. In addition, Al-Maharma *et al.* (2021:1) explain that caring behaviour promotes a sense of wholeness, comfort, dignity and inner peace that transcends the fear of childbirth and trauma, thereby enhancing the labouring women's ability to cope. This implies that midwives' moral and ethical caring behaviour should be displayed in a way that will influence the

labouring women to feel comforted. As a result, builds trust, hope and confidence in them.

## **2.6 Women's expectations of caring behaviour during childbirth**

Women hope for and anticipate caring behaviour in midwives during childbirth and expect continuous emotional, physical, spiritual and psychological support (Al-Maharma *et al.* (2021:2) and Khresheh *et al.* (2019:4). The accomplishment of women's expectations is recognised as the most important predictor of overall satisfaction and an indicator of the quality of maternal healthcare.

Mårtensson *et al.* (2020:1123); Anderson *et al.* (2020:12); and Khresheh and Barclay (2019:70) emphasise that labouring women feel valued and their expectations fulfilled when midwives respect their dignity, praise them, provide individualised care and consistently listen to them and answer their questions truthfully. Moreover, the labouring women need to be involved in decision-making about their care, informed about the progress of their labour and have their needs attended to. Khresheh *et al.* (2019:3-4) and Dzomeku *et al.* (2018:2) explain that women want their midwives to be emotionally and physically present in the labour room, providing support until the end of the childbirth, thereby helping them to have self-control during childbirth.

Bohren *et al.* (2019:1750) maintain that a women's experiences in a healthcare facility determine whether they will use it again and recommend it to others. Machira and Palamuleni (2017:30) argue that when midwives fail to meet women's expectations, their behaviour is considered uncaring, which gives rise to feelings of neglect and mistrust.

## **2.7 Uncaring behaviour of midwives during childbirth**

Uncaring behaviour suggests that midwives do not respect women's basic human rights during childbirth (John *et al.*, 2020:165; Khresheh *et al.*, 2019:1; Bowser & Hill, 2010:3-5), which includes respect for women's autonomy, dignity, feelings, choices and preferences. Bowser and Hill (2010:1) and the White Ribbon Alliance (2011) initiated the exploration of evidence of uncaring behaviour during facility-based childbirth and described six categories of disrespectful care during childbirth: physical and verbal abuse, unconsented procedures, unsupportive care, a lack of confidentiality and discrimination. These uncaring behaviours were identified as a

significant global public health matter of concern that requires attention (John *et al.*, 2020:165; Bradley *et al.*, 2019:2; Bohren *et al.* 2019:2; WHO, 2018b) because compromised maternal healthcare service delivery makes women feel disrespected, disappointed and humiliated.

Bohren *et al.* (2019:7) investigated how women were treated during facility-based childbirth in four countries in sub-Saharan Africa. The results found that 41.6% of the 2016 women observed (n=838) had experienced physical or verbal abuse as well as stigma and discrimination. Notably, uncaring behaviour such as physical and verbal abuse peaked between 30 minutes before and 15 minutes after birth, which is the critical period during childbirth and requires midwives' sensitivity and enabling support (Swanson 1991; Watson 2008). The reason for the increased risks might be that the midwives were more likely under pressure because of the demanding and negative attitude of the labouring women.

Moreover, John *et al.* (2020:168) conducted a study to determine women's experience of respectful maternity care and midwives' caring behaviour in Nigeria, which revealed both caring and uncaring behaviour. The results showed that 69.9% of 100 women (n=58) reported positive caring behaviour, such as being informed about the progress of their labour and general support, while 30.1% of 100 respondents (n=25) reported uncaring behaviour. However, those who reported uncaring behaviour experienced different types of abuse occurring in clusters, including a lack of privacy, verbal abuse, being scolded or shouted at and the midwife's absence when needed. This implies that women were unable to obtain the optimal care during childbirth that ensures their dignity, which required greater compliance with the WHO's (2018:200) recommendations for the prevention and elimination of uncaring behaviour during childbirth.

Mesenburg *et al.*'s (2018:4-5) study found that uncaring and abusive treatment contributed to a non-consented care rate of 55% rate. This was congruent with the results of Bohren *et al.*'s (2019:1756) study, which showed that 71.2% of 2016 women (n=1435) did not give consent for an episiotomy, and 49.7% of 2016 women (n=1214) did not consent to a vaginal examination. Therefore, these studies indicated that the incidence of uncaring behaviour in maternity units was increasing, and the implications



were likely to influence women not to trust midwives and to experience their care as unjust.

## **2.8 Implications of uncaring behaviour in midwives**

Uncaring behaviour implies that women's expectations and right to receive the highest standard of maternal care during childbirth are not met (John *et al.*, 2021:168; Aktaş & Aydin, 2019:188; Homer *et al.*, 2019:9). Furthermore, the literature indicates that uncaring behaviour compromises maternal health care service delivery and quality care during childbirth. Moreover, women lose trust and confidence in midwives (Khresheh *et al.* 2019:2) and midwifery care services, which are ethically required to be physically present during labour and childbirth.

John *et al.* (2020:166), Weldearegay *et al.* (2020:2) and Machira and Palamuleni (2017:30) maintain that women who have been exposed to the uncaring behaviour of midwives tend to be reluctant to seek midwifery care at the same facility or unit, as they have experienced post-partum traumatic stress, which could negatively influence future birth choices or their decision whether to have children again, such as prolonged period before having another child. Moreover, studies have shown that women choose a place of delivery based on their expectations of the way they will be treated (John *et al.*, 2020:168; Homer *et al.* 2019:9). These findings are congruent with those of other studies, which revealed that uncaring behaviour in midwives is still a general public concern in facility-based childbirth, and women are more likely not to trust midwives when they have experienced unjust care (Munabi-Babigumira *et al.*, 2017:3; Bradley *et al.*, 2019:2-5).

John *et al.* (2020:168) Bohren *et al.* (2019:1756) and Shallow *et al.*, (2018:1) identify various factors why midwives are uncaring, which has a significant impact on themselves, women and the maternal care system. These factors include a shortage of staff, work overload, inadequate equipment, a lack of appropriate physical space and inconsistent professional development. Furthermore, Houghton *et al.* (2020:11) and Munabi-Babigumira *et al.* (2017:4) argue that a lack of appropriate physical space caused by an influx of labouring women eventually hampers midwives' ability to adhere to global competency standards for midwives (Fullerton *et al.*, 2019:1) and maintain standards of care despite their professional skills and knowledge. In addition, a shortage of staff and heavy workloads increase midwives' fatigue, which dramatically

compromises quality midwifery care (Houghton *et al.*, Biesty, 2020:11) and is exacerbated by pressure to show caring behaviour in the face of the high labouring women turnover rates.

Once again, uncaring behaviour from midwives not only harms women's emotional well-being but also violates their rights to the highest attainable standard of healthcare during childbirth (Fullerton *et al.* 2019:1; Lambert *et al.* 2018:1; Munabi-Babigumira *et al.* 2017:4; Bowser & Hill, 2010:2). Moreover, uncaring behaviour harms the maternal healthcare system in the form of medical malpractice litigations against healthcare professionals (Spenser, Du Preez & Minnie, 2018:5). Therefore, the Commission for Gender Equality in South Africa has called for legal action and the criminalisation of abusive, humiliating and uncaring midwifery practice (Rucell *et al.*, 2019:1-4). In addition, the WHO's recommendations for intrapartum care and positive childbirth experiences emphasise the implementation of strategies for the prevention and elimination of the uncaring behaviour of midwives in facility-based childbirth (Bradley *et al.* 2019:2; WHO, 2018:195-200). Furthermore, the WHO (2018:1) recommends action, research and advocacy against uncaring behaviour in facility-based childbirth. The main thrust of caring behaviour is to ensure that every woman attains the highest standard of maternal care during childbirth. Therefore, midwives are responsible for carrying out midwifery healthcare standards that promote a conducive, safe and respectful healthcare environment during childbirth.

## **2.9 Midwifery practice standards**

Midwifery practice is based on existing standards, protocols and guidelines for essential intrapartum care. The WHO (2018:195-200) and Chabeli, Malesela and Nolte (2017:9-19) maintain that every woman has the right to the highest attainable standards of maternal healthcare during pregnancy, labour, childbirth and after birth. Therefore, midwives are obligated to provide supportive care, which increases women's satisfaction during childbirth and creates a positive birth experience (ICM, 2018:8-18; NMHW, 2013). In addition, practice standards emphasise that midwives have the responsibility to develop partnerships with women, and their families to participate in their care so that they can share relevant information that can lead to informed decision-making (Beek *et al.*, 2019:5). Moreover, midwives are obliged to recognise and support the rights of women to attain the highest standard of care in

facility-based childbirth (Bowser & Hill, 2010:3-5), which is a blanket mandate for many countries, including Botswana.

## **2.10 Overview of the health care system in Botswana**

The health policy of Botswana as in other countries indicates that women must give birth in health facilities and be cared for by skilled midwives during pregnancy, labour, childbirth and the postpartum period, including care of the new-born (MoHWs, 2011b; Republic of Botswana, 1967). The public healthcare system of Botswana, which is a land-locked and middle-income country with an estimated population of 2.4 million sharing boundaries with Namibia, Zambia, Zimbabwe and South Africa (Statistics Botswana, 2020), is run by the Ministry of Health and Wellness (MoHW). The MoHW is responsible for coordinating and leading the health sector, as well as formulating policies, standards, regulations and guidelines in collaboration with other stakeholders and supervising all resources necessary for the delivery of health services (MoHW, 2013). Moreover, the MoHW has to ensure that quality and affordable health services are delivered to all its customers and stakeholders, including private health care services (MoHW, 2011c).

The country is divided into 10 administrative districts and subdivided into 26 health districts, which are managed by the DHMTs responsible for the provision of public healthcare in both rural and urban districts (Statistics Botswana, 2015). The healthcare system is structured into six levels of service delivery: referral hospitals, district hospitals, primary hospitals, clinics, health posts and mobile stops (Statistics Botswana, 2015). Healthcare providers deliver services based on the National Quality Health Standards for each of the six levels of service delivery.

### **2.10.1 National Quality Health Standards in Botswana**

The Botswana Ministry of Health and Wellness set the National Quality Health Standards that guide healthcare in the country (MoHW, 2013). In April 2018, the WHO in collaboration with the United Nations Population Fund (UNFPA), assisted Botswana's MoHW by monitoring and evaluating its National Quality Health Standards. This was aimed at ensuring that national and international developments in healthcare (community health services, integrated health services and clinical support services) were addressed and that effective, efficient, appropriate, accessible,

responsive and evidence-based health services were delivered at all levels of care in Botswana. Moreover, the National Quality Health Standards ensured the provision of essential services that are caring, transparent, politically neutral, reliable, responsive, proactive, accountable and customer and stakeholder-focused (MoHW, 2013).

#### ***2.10.2 Healthcare standards in midwifery practice in Botswana***

As indicated earlier, the Ministry of Health and Wellness sets quality health standards for the service delivery for all levels of care including midwifery practice (MoHW) that are used as guidelines for practising registered midwives in maternity units. The Nurses and Midwives Act of 1976 (Republic of Botswana, 1967:15-21) indicates the roles, functions, responsibilities and activities legally required of a midwife. The standards expected of midwives as professional healthcare providers ensure the provision of quality midwifery services to the public, through the enforcement of respectful, dignified, culturally sensitive and safe care to women during childbirth (Public Health Services, 2015).

The Nurses and Midwives Act of 1997 expects nurse midwives to be receptive, patient, compassionate and knowledgeable about their work (Republic of Botswana, 1995:15-21). In addition, according to the Mission, Vision and Values of the MoHW, they must maintain professional values and accountability in providing quality care with a level of competence that promotes public confidence (MoHW, 2011c). Moreover, according to the Registered Midwives Disciplinary and Ethical Rules, 1969 (Republic of Botswana, 1969:14), a midwife's conduct should be acceptable at all times and not harmful to the woman's interests, condition, safety and well-being. Midwives are, furthermore, responsible for fostering teamwork to promote a healthcare environment that is conducive, safe and bound to therapeutic and ethical practice during healthcare delivery.

The literature shows, however, that uncaring behaviour from midwives in maternity units is increasing, which requires the development of strategies that could be used to optimise caring behaviour. As a result, positive birth outcomes will decrease the number of complaints about the uncaring behaviour of midwives in facility-based childbirth.

## **2.11 Summary of the chapter**

This chapter explained some of the literature on the caring behaviour of midwives focusing on the care of facility-based childbirth in low- middle- and high-income countries, although the emphasis was placed on Botswana. Studies have revealed that midwives' uncaring behaviour towards labouring women, such as verbal/physical abuse and unconsented care is currently a matter of public concern. In addition, studies have shown that various factors inhibit caring behaviour in midwives, which means that women have a negative experience of childbirth. However, despite the concern, mostly qualitative research has been conducted, which indicates the value of the current quantitative study.

In the next chapter, the researcher will provide a detailed discussion of the research design and methods.

## **CHAPTER 3**

### **RESEARCH DESIGN AND METHODS**

#### **3.1 Introduction**

The previous chapter presented the literature on the caring behaviour of midwives with a focus on the requirements for midwifery in Botswana. This chapter describes the research design and methods followed in the study to answer the research questions and achieve the research objectives. The research objectives were to identify and describe the caring behaviour of midwives in Botswana, determine the factors that inhibit their caring behaviour of midwives and make recommendations for midwives and unit managers that could be used to optimise the caring behaviour of midwives in Botswana

In the chapter, the research design will be described followed by the research methods. The population, sampling, methods of data collection and analysis, and the pilot study will be described in detail. Thereafter, the rigour or quality of the research and the ethical principles that were upheld throughout the study will be described.

#### **3.2 Research objectives**

The objectives of this study were threefold:

- i. identify and describe the caring behaviour of midwives who nurse women during childbirth in Botswana;
- ii. determine the inhibiting and facilitating factors of caring behaviour of midwives who nurse women during childbirth in Botswana; and
- iii. make recommendations for midwives and unit managers that could be used to optimise caring behaviour of midwives when nursing women during childbirth in Botswana.

#### **3.3 Research design**

To answer the research questions and achieve the research objectives, the study described in this dissertation followed a quantitative, descriptive research design. In the next section, a quantitative research design is explained, whilst the section thereafter explains a descriptive research design.

Gray *et al.* (2017:52) define a research design as a general plan or a blueprint that outlines the implementation of a study that seeks to answer research questions and achieve research objectives. Fain (2017:151) maintains that a research design determines the methods used in a study, which include those used for sampling, data collection and data analysis.

### **3.3.1 Quantitative research design**

A quantitative research design is a formal, systematic process whereby numerical data are collected and analysed to answer the research questions (Gray *et al.*, 2017:25). The results of the data analysis are then generalised to the population (Polit & Beck, 2018:415; Jooste, 2018:330; Fain, 2017:155). Moreover, a quantitative research design determines how the data in the form of numbers are gathered and statistically analysed to produce descriptive or inferential statistics, which are interpreted and discussed in light of the research questions and objectives (Gray *et al.*, 2017:349; Harvey & Land, 2017:50; Fain, 2017:215).

The quantitative research design of the study described in this dissertation indicated that a survey method of data collection using a structured, self-administered questionnaire would be appropriate and that descriptive and inferential statistical analysis would be suitable for drawing meaning from the numerical data, which had been captured on Microsoft Excel® spreadsheets and then, analysed using SPSS® software to identify and describe the caring behaviour of midwives who nurse women during childbirth in Botswana.

### **3.3.2 Descriptive research design**

A descriptive research design is followed when information is gathered to describe a phenomenon, population or real-life situation systematically (Gray *et al.*, 2017:676; Fain, 2017:25). According to Grove and Gray (2019:202) and Polit and Beck (2018:400), a descriptive research design indicates how a researcher can identify traits, trends, categories and frequencies. A researcher follows this type of design when he/she needs to answer questions that ask what, when and questions as opposed to qualitative research that asks why and how questions (Fain, 2017:25; Gray *et al.*, 2017:70). In quantitative research, numerical data are gathered and statistically analysed to answer these questions (Grove and Gray, 2019:202). In the study

described in this dissertation, the data gathered from practising midwives in Botswana were analysed to find answers to questions concerning the caring behaviour of midwives who nurse women during childbirth.

### **3.4 Research methods**

The specific methods or strategies followed to conduct a study are determined by the research design (Moule *et al.*, 2017:34) to answer the research questions and achieve the research objectives (Gray *et al.*, 2017:52). The following sections explain the methods that the researcher used to select the study sites, target population and sample. Moreover, these sections explain the data collection method, the data collection instrument and the data analysis method.

#### **3.4.1 Study sites**

The study sites for the research were selected by the researcher using the purposive, non-probability method, which meant that she relied on her judgement in choosing them. The sites were chosen because they are the main maternity units in the study area and are responsible for around 11165 births per year (Statistics Botswana, 2022). In other words, the researcher could be sure that respondents from those sites would have been able to give a clear description of the caring behaviour of midwives in facility-based maternity units in Botswana.

Gray *et al.* (2017:352) and Fain (2017:151) describe a study site as the overall location where research is conducted, which in the current study, was two out of the ten health districts in Botswana, namely the Kgatleng and the Greater Gaborone DHMTs in the South-East District of Botswana. Most of the maternity units in these districts were only 40 kilometers from each other; easy to reach from a cost and time perspective (Maree, 2016:36) and could be visited during and after working hours. However, the furthest facility was approximately 100km away from the others, although the researcher still managed to access it.

Kgatleng DHMT has six maternity units. In addition, it has a maternity unit within a public district hospital. The Greater Gaborone DHMT also has six maternity units. Moreover, it has a maternity unit within a public referral hospital (Statistics Botswana, 2020). These units represent the full range of the different types of facilities and levels of healthcare available in districts in Botswana: referral hospitals, district hospitals and



clinics with maternity units. Although there are private hospitals in the study area, they were not included in the study because their focus was on public health facilities.

### **3.4.2 Research population**

According to Jooste (2018:334), Polit and Beck (2018:413) and Moule *et al.* (2017:165), a research population is defined as all the members of a defined group who share a specialised set of characteristics about which a researcher is interested in gathering information. In other words, a population consists of the entire group of people or elements that represents the focus of the research (Grove *et al.*, 2017:53). The research population of the study was professional midwives working in maternity units in Botswana.

### **3.4.3 Target population**

Moule *et al.* (2017:165) and Grove *et al.* (2017:694) define a target population as a group of people from which a researcher would like to draw information and the composition of which meets specific criteria or represents a particular set of traits. In addition, a researcher makes generalisations, inferences or assumptions after studying a target group (Polit & Beck, 2018:162). The eligible target population for the current study was all professional midwives working in the maternity units of the Kgatleng and Greater Gaborone DHMTs who met the inclusion and exclusion criteria for the study, as indicated in Table 3.1 below.

**Table 3.1: The target population for the study**

Name of the district	District/referral hospital with a maternity unit	Clinics with a maternity unit	Number of midwives
Kgatleng DHMT	1	5	76
Greater Gaborone DHMT	1	5	124
Total target population	2	10	200

### **3.3.4 Sampling**

As indicated in Chapter 1, according to Polit and Beck (2018:413) and Jooste (2018:335), sampling is the selection of respondents from the target population. Purposive, non-probability sampling was used for selecting the respondents who met

specific inclusion and exclusion criteria in the current study (Grove & Gray, 2019:230; Malesela, 2018:6).

### **3.4.5 Sample**

As indicated in Chapter 1, a sample is a representative subset of the target population selected for participation in a study (Polit & Beck, 2018:417; Jooste, 2018:335; Fain, 2017:135). The sample for the study was selected from the target population of professional midwives working in maternity units of the Kgatleng and Greater Gaborone districts.

### **3.4.6 Sample size**

Polit and Beck (2018:417) and Moule *et al.* (2017:167) maintain that the sample size is the number of respondents included in a research study. In the study, 200 professional midwives working in maternity units met the inclusion and exclusion criteria, and thus participated in the study. Therefore, the sample comprised the whole target population.

### **3.4.7 Recruitment of respondents**

Recruitment refers to the soliciting of respondents for a study (Gray *et al.*, 2017:354; Burns *et al.*, 2015:310). The recruitment of respondents was based on inclusion and exclusion criteria.

#### **3.4.7.1 Inclusion criteria**

The inclusion criteria were that the midwives had to have the following:

- Permanent positions in maternity units in the Kgatleng and Greater Gaborone health districts
- Six or more months of work experience in maternity units
- Valid midwifery practice license certificates from the Nursing and Midwifery Council of Botswana (NMCB).

#### **3.4.7.2 Exclusion criteria**

The exclusion criteria were as follows:

- Unit managers of maternity units who did not actively care for women during childbirth

- Midwives who worked on a rotational basis in the units

### **3.4.8 Data collection method**

The data collection method used in the study was a survey using a questionnaire as the data collection instrument. However, before data collection could begin a preliminary process had to be followed as explained below.

#### **3.4.8.1 Data collection process**

A data collection process is a formal standardised method for obtaining approval to conduct a study (Polit & Beck 2018:201; Fain, 2017:315). The first step in the process for the current study was to obtain ethical approval to conduct the study from the Nelson Mandela University Research Ethics Committee – Human (REC-H). The reference number of the approval was H20-HEA-NUR-010 (see Annexure A) (Gary, Grave & Sutherland, 2018:494; Jooste, 2018:309, 344; Harvey & Land, 2017:206).

Thereafter, permission to conduct the study had to be obtained in writing from the following:

- Permanent Secretary to the Ministry of Health and Wellness (see Annexure B)
- Health Research and Development Division Committee in Botswana (see Annexures C and D)
- DHMT Coordinators, Hospital managers and superintendents of the two health districts (see Annexures E and F)

The researcher then met the managers of the maternity units at their respective working facilities to introduce herself and obtain permission to recruit respondents, as recommended by Harvey and Land (2017:207). Moreover, authority was obtained from the unit managers (gatekeepers) to gain access to the research sites for a meeting with the respondents (see Annexure G). The gatekeeper's role was to pave the way for the researcher's entry into the selected sites to meet, recruit and inform the respondents about the study (Polit & Beck, 2018:54).

After gaining access to the site, the researcher met face-to-face with the respondents. In addition, unit managers assisted the researcher by making arrangements with midwives to meet the researcher during their shifts, when a brief overview of the study was presented.

#### 3.4.8.2 *Data collection instrument*

A data collection instrument is a formally designed device used to collect data (Polit & Beck, 2018:406; Fain, 2017:215). In the study, a structured, self-administered questionnaire (see Annexure H) was developed by the researcher based on the literature review as the research instrument for collecting data to answer the research questions and achieve the research objectives.

The questionnaire was divided into three sections. Section A comprised the demographic attributes of the respondents: age, gender, qualification level, years of work experience as a midwife, years of work experience in the ward or unit, work location and level of work satisfaction. Section B contained 21 question statements to identify and describe the caring behaviour of midwives who nurse women during childbirth in Botswana. Section C consisted of 22 question statements to determine the factors inhibiting caring behaviour.

The statements were closed-ended and measured according to a five-point Likert scale. Polit and Beck (2018:170) and Fain (2017:222) indicate that closed-ended questions provide a greater uniformity of responses, which, are easily captured, processed and statistically analysed.

The questionnaire had been prepared in English because all respondents were fluent in this language and therefore there was no need for a language translator. The questions were constructed in such a way that they were easy to understand, thereby ensuring that all the respondents interpreted the questions the same way. Moreover, the duration of the completion of the questionnaire was estimated to be 20 to 30 minutes. The questionnaire did not require the respondents to divulge any personal information, thereby giving the respondents a feeling of anonymity and encouraging honest responses (see Annexure H).

#### 3.4.8.3 *Administration of the questionnaires*

Face-to-face administration of the questionnaire (Polit & Beck, 2018:168; Fain, 2017:215) took place when the researcher was in contact with the respondents at their workplace, for example, clinics and hospital maternity units (see Annexure H). The decision to administer the questionnaire in this way was because Harvey and Land

(2017:207) indicate that respondents must be visited in their clinical setting to ensure that there was no interruption to or delay in their daily work activities.

Written, informed consent was obtained from each respondent who voluntarily participated in the study (see Annexure G). Then, the questionnaires were completed in private areas in ward conference rooms and took between 20 and 30 minutes to complete after which they were collected immediately by the researcher. Arrangements were made with the respondents who were on different shifts for the administration of the questionnaires at a convenient time

Respondents were provided with envelopes in which to place the signed consent forms, which were not to be linked with the completed questionnaire to ensure anonymity and confidentiality (Polit & Beck, 2018:82; Fain, 2017:37; Gray, *et al.* 2017:170). Questionnaires that were not completed within the expected time during the administration were left with the respondents to be completed later and submitted to the manager's office in sealed envelopes and placed into the box provided where they would be kept in a safe place under lock and key until collected by the researcher. The completed sealed questionnaires and consent forms were collected within two or three days according to the arrangement made with the respondents and the managers. This decision was made to secure an adequate response rate and allow the respondents to answer the questions properly.

Data were gathered between March and May 2021 from 200 respondents who had volunteered to participate in the study. As the research was conducted during the COVID-19 pandemic, the researcher had to adhere to the regulations and protocols for face-to-face engagement, which meant the facilities operated with a skeleton staff to avoid overcrowding at workplaces, and it was not possible to meet the potential respondents at times (MoHW, 2020:1; Tremblay *et al.*, 2021:2).

### **3.5 Pilot study**

A pilot study is a small-scale trial run of the main study using a small sample representative of the target population to test the data collection instrument for reliability and validity (Moule *et al.*, 2017:339). Whitehead *et al.* (2016:1057,1071) suggest that a pilot study sample size should be 10 to 40 respondents or 10% of the larger sample used in the study. Thus, a pilot study was conducted with 10 midwives drawn from the target population to make sure that the questions were reliable and

valid. The sample size was determined based on the recommendations made by a Nelson Mandela University statistician. The respondents' responses indicated that they had interpreted the questions correctly and provided useful information. The questionnaire took midwives 20 to 30 minutes to complete. Therefore, the questions were deemed sufficiently clear, and they effectively solicited the desired information. However, the results of the pilot study were not included with those of the main study but are presented in the summary of the study later in this dissertation.

### **3.6 Data analysis**

According to Moule *et al.* (2017:346) and Fain (2017:265), data analysis is the process of organising and summarising data to obtain answers to the research questions and achieve the research objectives. After the data collection, the researcher cleaned and captured the data on Microsoft Excel® spreadsheets. The data were then screened for missing words where possible and then subjected to statistical analysis with the assistance of a Nelson Mandela University statistician using SPSS® Version 27 (IBM Corp, 2020).

#### **3.6.1 Descriptive statistics**

Descriptive statistics describe and summarise the characteristics of numerical data, thereby giving meaning to the collected information (Fain, 2017:265; Harvey & Land, 2017:50). In the study, descriptive statistical analyses were performed using SPSS® Version 27. Continuous variables were summarised in terms of a mean (M) and standard deviation (SD). Medians and interquartile ranges were used for variables that were highly skewed or had significant outliers. Categorical and ordinal variables were summarised using proportions and percentages.

#### **3.6.2 Inferential statistics**

Polit and Beck (2017:238) and Fain (2017:265) describe inferential statistics as statistics that draw conclusions about data, which can lead to generalisations about the target population. In the current study, inferential statistics were generated using Pearson's chi-square test or Fisher's exact test, as appropriate. Pearson's correlation coefficient measured the linear dependence. Inferential statistics also indicate the strength of the relationship between variables. Chi-squared tests were used to determine the relationship between the variables in the study (Weldearegay *et al.*

2020:5; Polit & Beck, 2018:245; Fain, 2017:284). The results of the data analysis are presented in the form of tables and charts in Chapter 4 of this dissertation. Moreover, they are interpreted in terms of Swanson's (1991) Theory of Caring and the research questions and objectives in Chapter 4.

### **3.7 Quality of the study**

The quality and integrity of a study depend on the reliability and validity of the data collection instrument (Fain, 2017:245; Harvey & Lan, 2017:290). Therefore, a researcher needs to ensure that the instrument consistently and accurately measures what it is intended to measure. Reliability and validity will be discussed below.

#### **3.7.1 Reliability**

According to Moule *et al.* (2017:184) and Fain (2017:245), reliability refers to the level of consistency and uniformity with which an instrument measures what it is intended to measure. The reliability of an instrument is the extent to which the results obtained remain the same if the instrument is re-administered to the same object of measurement (LoBiondo-Wood & Haber, 2018:270; Gray *et al.*, 2017:690). In the study, a pilot study was conducted to determine the reliability of the questionnaire by using it in a different situation and discovering if it obtained results that were consistent with those of the main test. This meant that the respondents should interpret the questions of the questionnaire in the same way. The results of the main test were consistent with those of the pilot study, which proved that the measuring instrument was reliable.

#### **3.7.2 Validity**

According to Fain (2017:250) and Harvey and Land (2017:292), validity refers to the ability of a questionnaire to measure accurately what it is intended to measure. The instrument must cover the complete content of the construct that it is supposed to measure. In the study, the questionnaire was presented to the supervisors, a statistician and other reviewers from the Research Ethics Committee of Nelson Mandela University to evaluate the instrument for validity. The pilot study, which was discussed above also proved that the questions were valid because answers were elicited that provided information on the constructs being measured.

### 3.7.2.1 *Face validity*

Face validity is a subjective assessment by an expert that verifies that an instrument appears to measure the content it is supposed to measure (Gray *et al.*, 2017:678; (Polit & Beck, 2018:176). Therefore, the researcher constructed questions that seemed valid for the study and that the respondents would perceive as measuring the concepts about which they had agreed to provide information (Gray *et al.*, 2017:376). Moreover, the face validity had to be verified by the supervisors, a statistician and other relevant authorities from the Research Ethics Committee of Nelson Mandela University.

### 3.7.2.2 *Content validity*

Fain (2017:250) and Harvey and Land (2017:292) define content validity as the extent to which the instrument measures all aspects of the content it is intended to measure. The questionnaire was constructed using the concepts described in Chapter 1 of the dissertation as the variables being measured. Gray *et al.* (2017:197) maintain that content validity is ensured through the inclusion of all aspects of the concepts the measuring instrument purports to measure.

The researcher reviewed the literature before developing the instrument to make sure that all the necessary variables were included in the questionnaire. In addition, the questionnaire was reviewed by the supervisors, a statistician and other reviewers from the Research Ethics Committee of Nelson Mandela University who evaluated the instrument for content validity.

## 3.8 **Research ethics**

Research ethics require the researcher to conform to accepted standards of behaviour and practical procedures that researchers are expected to follow when conducting human research, as outlined in the National Health Research Ethics Council for the Protection of Human Subjects of Biomedical and Behavioural Research (DoH, 2015). Ethical approval was obtained from the Nelson Mandela University Research Ethics Committee – Human (REC-H) with the reference number: H20-HEA-NUR-010; (see Annexure A) and from the Ministry of Health and Wellness, Health Research Development Committee (HRDC) with the reference number: HPDME13/18/1 (see Annexure D).



Fain (2017:28) points out that adequate protection of research subjects may cause a delay in the research study. Furthermore, Jooste (2018:309) contends that maintaining the safety and human rights of respondents must be always a priority. Likewise, the research principles intended to safeguard the human rights of the respondents were adhered to throughout the study as discussed below.

### **3.8.1 *Informed consent***

According to Polit and Beck (2018:417), Jooste (2018:311) and Fain (2017:38), informed consent is a respondent's voluntary agreement to participate in a study. To obtain informed consent, a brief overview of the study was presented to the respondents for them to make an informed choice about whether to participate or not. An information document was given to the respondents to read and understand what they were required to do (see Annexure G). The information document provided detailed information about the study and explained that participation was completely voluntary. Midwives were requested to sign the consent form before completing the questionnaire (see Annexure G). Thus, respondents were freely allowed to participate and withdraw from the study at any stage without penalties, although none of the respondents withdraw from the study.

### **3.8.2 *Respect for persons and autonomy***

The principle of respect for persons and autonomy indicates that respondents should be treated with respect and viewed as autonomous agents (Jooste, 2018:312; Gray *et al.*, 2017:163; Fain, 2017:35). Moreover, respondent's opinions and choices were respected. Respondents were provided with information about the study. They were allowed to choose whether to participate or not and withdraw thereafter if they so desired, even though they had consented to participate in the study by signing the consent form.

They were treated with respect and kindness. Midwives were not coerced or forced, nor pressured to participate in the study. Informed consent was obtained from the midwives before the completion of the questionnaire (see Annexure H). The respondents were also requested to complete the questionnaire individually to avoid biased answers. Midwives were requested to submit the completed sealed

questionnaire by posting it in a box, which was provided by the researcher before the data collection process started.

### **3.8.3 Anonymity and confidentiality**

The principle of anonymity and confidentiality means protecting the privacy and dignity of respondents by not divulging the information gathered from them to others (Polit & Beck, 2018:82; Fain, 2017:37; Gray *et al.*, 2017:170). Anonymity and confidentiality were ensured by not revealing the respondents' names and the information that they had given. Respondents were given numbers (raw data) to prevent linking their identities to the information that had been gathered, in the research report and articles to follow.

Even the researcher could not link the data to the respondents because they were requested not to write their names on the questionnaires and were asked to write their names only on the consent forms. Moreover, the forms could not be linked to the data because they had been placed in envelopes, which were separate from the completed questionnaires.

The respondents were assured that their information would remain anonymous and confidential because only the researcher and the supervisors will have access to it and raw data would be safely kept only for five years in case it needed to be retrieved for some reason. During that time the forms and questionnaires would be locked away, and only the researcher would have access to them. In addition, data stored on a computer would be password protected.

### **3.8.4 Beneficence**

The principle of beneficence involves protecting respondents from physical, emotional and social harm due to the research (Polit & Beck, 2018:79; Gray *et al.*, 2017:173; Fain, 2017:34). Therefore, the researcher not only saw to the respondents' well-being and comfort but also made sure that they would not be exposed to any risks or harm, especially by ensuring their anonymity.

The researcher ensured their well-being and comfort by collecting the data when it was convenient for them, and they were allowed to complete the questionnaire in their own time, thereby not interrupting their normal duties. Moreover, convenient

arrangements were made with the respondents for the collection of the completed questionnaires.

Although the study did not have any direct benefit for the respondents, it might be beneficial to them in the long run through future changes in nursing policy, practice, education and research. Therefore, the researcher explained to the respondents that the results of the study would lead to recommendations that could be used to optimise the caring behaviour of midwives.

### **3.9 Dissemination of results**

The dissemination of the results of a study is the communication of the research outcomes to others, which in the case of the current study would include midwives, other health professionals and academics (Fain, 2017:302; Moule *et al.*, 2017:382). The researcher will ensure that a copy of the electronic version of this dissertation will be kept at the Nelson Mandela University library for public use. Another copy would be presented to the Human Research Development Division in Botswana. An article will be prepared for publication in a peer-reviewed academic journal. Moreover, the researcher will present papers at nursing and midwifery conferences and symposiums.

The respondents' rights to the data will be maintained (Jooste, 2018:313) by ensuring that at least one feedback session on the research outcomes is presented to them in a form of a workshop or in-service training. These sessions will be provided to ensure that all the individuals and facilities that participated in the study obtain the research results.

### **3.10 Summary of the chapter**

This chapter explained the research design and methods in detail, thereby providing information on the plan and strategies followed to conduct the quantitative, descriptive study. In addition, the chapter explained how reliability, validity and research ethics were ensured. The chapter ended with an explanation of the dissemination of the research outcomes. The next chapter will present, interpret and discuss the results of the data analysis.

## CHAPTER 4

### PRESENTATION, INTERPRETATION AND DISCUSSION OF THE RESULTS

#### 4.1 Introduction

In the previous chapter, the research design and methods of the study were discussed. In this chapter, the results will be presented, interpreted and discussed. The analysed data is presented in tables and pie charts, which organise the data to give meaning to the phenomenon under study (Polit & Beck, 2018:400).

#### 4.2 Data management and analysis

Data management and analysis organise the data and make them meaningful (Weldearegay *et al.*, 2020:5). In the study, data management involved organising the raw data by capturing them on Microsoft Excel® spreadsheets before they were imported into SPSS® Version 27 for cleaning and statistical analysis with the assistance of a statistician (Gray *et al.*, 2017:349; Fain, 2017:155).

Pearson's chi-squared test was utilised to investigate the association between the variables (Polit & Beck, 2018:245; Fain, 2017:284). According to Grove *et al.* (2018:134) and Maree (2016:229), the p-value is described as the probability that a statistical measure will be greater than or equal to or less than or equal to observed results. An insignificant p-value indicates that there is no relationship between the variables, and a significant p-value indicates there is some relationship between variables. A p-value less than 0.05 means that the relationship is statistically significant.

The relationship between the demographic variables of the respondents and their caring behaviour during childbirth as well as the association between the demographics and the inhibiting factors of the caring behaviour of midwives were. All analyses were performed using SPSS®, Version 27 (IBM Corp, 2020).

#### 4.3 Response rate

In the study, the response rate was the number of respondents who completed the questionnaire divided by the number of respondents who were asked to participate in the study (Polit & Beck, 2018:417). The initial sample consisted of 250 respondents of

whom 40 did not participate in the study because the study was voluntary, and they had the right to choose not to participate. Nevertheless, 210 questionnaires were returned, giving a total response rate of 84.0%. However, of these 210 questionnaires, only 95.2% (n=200) were completed, with the remaining 4.8% (n=10) not completed. Therefore, only the 200 completed questionnaires were analysed.

Table 4:1 below explains the response rate.

**Table 4.1: Response rate**

	Frequency (n=250)	Percentage (%)
Questionnaires distributed	250	100%
Completed	200	80.0%
Incomplete	10	4.0%
<b>Total response rate</b>	210	84.0%

#### **4.4 Presentation, interpretation and discussion of the results**

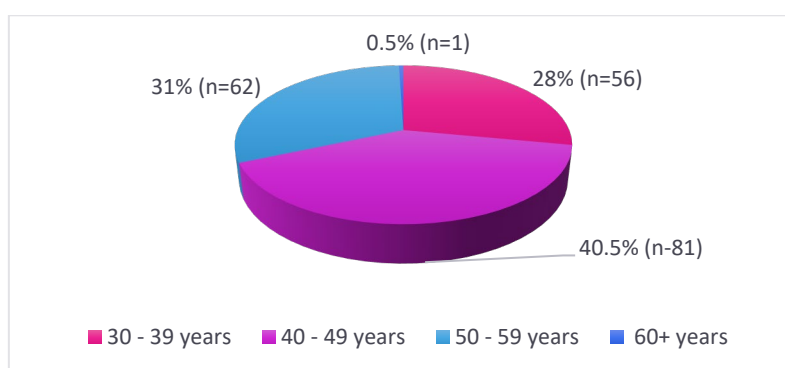
This section comprises the presentation, interpretation and discussion of results according to the sections of the questionnaire. The chapter is divided into three sections: Section A (the respondents' demographics); Section B (the caring behaviour of midwives); and Section B (the factors inhibiting the caring behaviour of midwives). The results prepared with the assistance of a statistician are presented in frequency tables, figures and charts.

##### **4.4.1 Section A: Respondents' demographics**

Demographic data were gathered to determine whether the respondents were a representative sample of the target population, which would mean that the study outcomes could be generalised (Polit & Beck, 2018:417). The questionnaire gathered data on the respondents' age, gender, education level, years of experience, years working in a unit or ward, work location and work satisfaction. The results are presented below.

#### 4.4.1.1 Age

Respondents were asked to indicate their ages for the researcher to determine the age distribution of midwives who nurse women during childbirth in Botswana. Figure 4.1 below presents a summary of the data on the respondents' age.



**Figure 4.1: Respondents' age**

The results showed that most of the respondents 40.5% (n=81) and 31% (n=62) were from 40 to 49 years old and 50 to 59 years, respectively, which implies that the respondents in the study were mature and experienced, which is similar to the results of the National Census (Statistics Botswana, 2020:29-32) indicating that most of the population falls between age category 40-49 years. Age is an important factor, as it could influence a midwife's commitment and level of autonomy, which is assumed to increase with age. As a midwife matures so does the likelihood that she/he could be responsible and committed to caring behaviour.

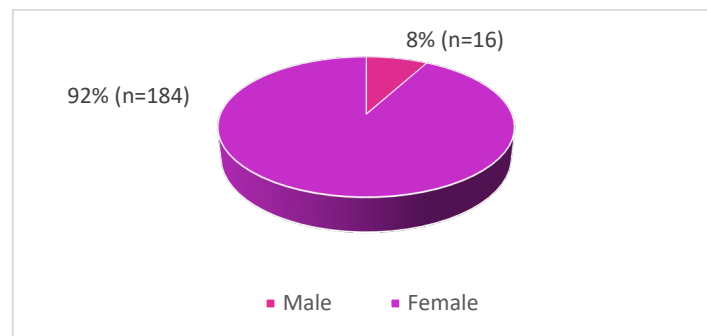
Mestdagh *et al.* (2019:4) maintain that older midwives are autonomous, responsible and committed in addition to having a sense of self-efficacy and being prepared to go the extra mile. This suggests that they might demonstrate caring behaviour when nursing women during childbirth. However, Zinsser, Stoll and Gross (2016:99) claim that age has little impact on midwives' behaviour during childbirth, which suggests that caring behaviour is not based on a midwife's age.

To determine whether there was a statistically significant relationship between the age of the respondents and their caring behaviour towards women during childbirth, Pearson's chi-squared test was performed. Polit and Beck (2018:284); Gray, Burns and Grove (2018:134) and Maree (2016:229) maintain that when the p-value calculated by the test is less than 0.05, there is a significant association, and a p-value greater than 0.05 indicates that there is no significant association. In the current study,

the p-value was 0.058, which indicates that there was no statistically significant association between the age of the respondents and the caring behaviour of midwives.

#### 4.4.1.2 Gender

The respondents were asked to indicate their gender to determine whether there was a relationship between the gender and caring behaviour of the midwives in the study. Figure 4.2 below presents a summary of the data on the respondents' gender.



**Figure 4.2: Respondents' gender**

Figure 4.2 above shows that female midwives 92% of (n=184) dominated representatives of the midwifery profession in the study. This result supports the literature, which indicates that females at times are more represented than males in several sectors because most countries and regions in the world have more females than males. In Botswana, the population census revealed that the female population amounted to approximately 1.21 million, whilst there were approximately 1.14 million males (Statistics Botswana, 2020).

The Nursing and Midwifery Council of Botswana Data Report (reference no: NMCB, 1/37/1 (27):2020 indicates that the number of practising registered midwives was 5267 of which 27.6% (n=1455) were males and 72.4% (n=3812) were females (NMCB, 2020). In addition, the Botswana Labour Force Module Report (Statistics Botswana, 2020:29-34) shows that of the total working population, 2.4% (n=48.007) males and 5.8% (n=63.742) females were employed in the health sector. This corroborates the study results that revealed that more females than males were midwives. However, the results might also suggest that the midwifery profession is stigmatised as a female profession.

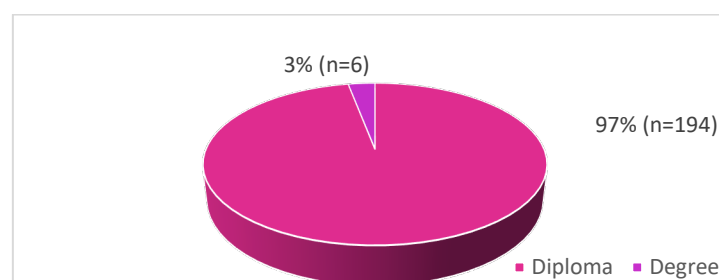
Although the study revealed more female midwives than male accoucheurs, Peprah *et al.* (2018:66) and the WHO (2018:195-200) recognised that well-trained and skilled professional midwives could safely handle childbearing women regardless of their gender.

Mthombeni, Maputle and Khoza's (2018:66) study found that male midwives were more sympathetic toward the needs of women during childbirth. However, some women felt embarrassed to be cared for by males because of their religious and cultural perceptions. Nevertheless, Mthombeni *et al.* (2018:66) recommend that more males should be allocated to facilities-based childbirth to allow women to become familiar with them.

To determine whether gender had a statistically significant relationship with the caring behaviour of the respondents Pearson's chi-squared test was performed. The result was a p-value of 0.343. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value is less than 0.05, there is a statistically significant association but when it is greater than 0.05, there is a statistically insignificant association. Therefore, the p-value of 0.343 showed that there was no statistically significant association between these two variables. Thus, although the literature indicates that gender is significant, the study revealed that there was no significant difference between male accoucheurs and female midwives because they both demonstrated caring behaviour.

#### 4.4.1.3 Education level

Respondents were asked to indicate their education level for the researcher to determine the relationship between education and the caring behaviour of midwives who nurse women during childbirth. Figure 4.3 below indicates the respondents' level of education.



**Figure 4.3: Level of education**



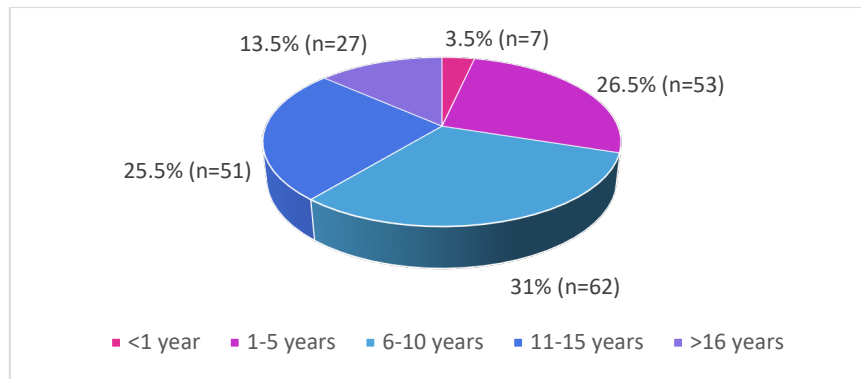
The results of Figure 4.3. above shows that most of the midwives 97% (n=194) had a diploma in midwifery studies compared with their colleagues who had a Postgraduate degree in midwifery. However, the results indicate that they both had basic skills and knowledge in midwifery practice, and they could demonstrate caring behaviour when nursing women during childbirth. This result adheres to Chapter 61.3 of the Nurses and Midwifery Act (Republic of Botswana:1995:4), which states that a midwife with a diploma could further his/her education after practising for a while in the midwifery field to gain experience and afterwards could advance to postgraduate midwifery studies or any speciality related to midwifery practice. Moreover, this result explains the reason why degree holders constitute smaller percentages.

This result was also consistent with that of Lohmann *et al.* (2018:2) study, which revealed that midwives tend to qualify with a diploma in midwifery education in Germany more than those who had postgraduate degrees in midwifery. However, the ICM (2017:1) and Munabi-Babigumira *et al.* (2017:4) emphasise that every midwife has the right to midwifery-specific education that will enable him/her to develop and maintain competency as a midwife.

Pearson's chi-squared test was performed to investigate the relationship between the educational level of the midwives and their caring behaviour towards women during childbirth. The results affirmed that there was no statistically significant association between these two variables at  $p=0.062$ . Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association.

#### **4.4.1.4      *Years of work experience as a midwife***

The respondents were asked to indicate their years of work experience as midwives, for the researcher to determine whether there was a relationship between work experience and the caring behaviour of the respondents. Figure 4.4 below indicates the number of years the respondents had been midwives.



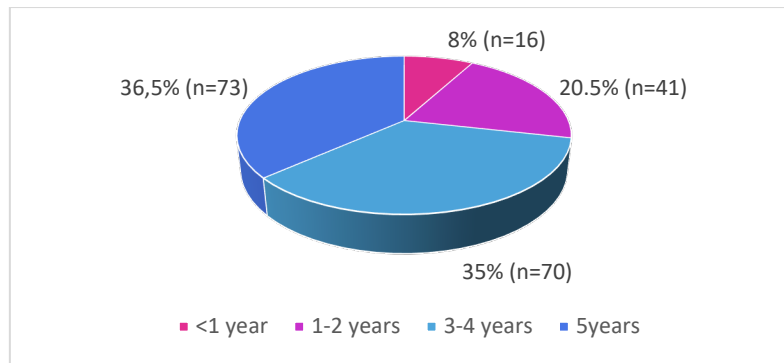
**Figure 4.4: Years of work experience as a midwife**

Figure 4.4 above shows that most of the respondents 31% (n=62) had more than 6-10 years of work experience as midwives, and 3.5% (n=7) had less than 1 year. This implies that midwives with many years of work experience as midwives might have skills and knowledge in the caring behaviour needed by women during childbirth. Studies by Khresheh *et al.* (2018:2) and Ndwiga *et al.* (2017:11-12) emphasise that more experienced midwives tend to have advanced skills and knowledge, which ensure that labouring women experience positive caring during childbirth. The literature agrees with current study results because results show that most of the midwives in the study 31% (n=62) had 6 to 10 years of work experience in caring for women during childbirth.

Using Pearson's chi-squared test to investigate the relationship between the number of years working as a midwife and caring behaviour towards women during childbirth, the researcher found that there was no statistically significant association between these two variables ( $p=0.0597$ ). Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association.

#### 4.4.1.5 Years of work experience as a midwife in the same unit/ward

The respondents were asked to indicate the duration of work experience in the same unit/ward for the researcher to establish whether there is a relationship between this variable and their caring behaviour during childbirth. Figure 4.5 below presents the number of years the respondents had been working in the same unit/ward.



**Figure 4.5: Years working in the same unit/ward**

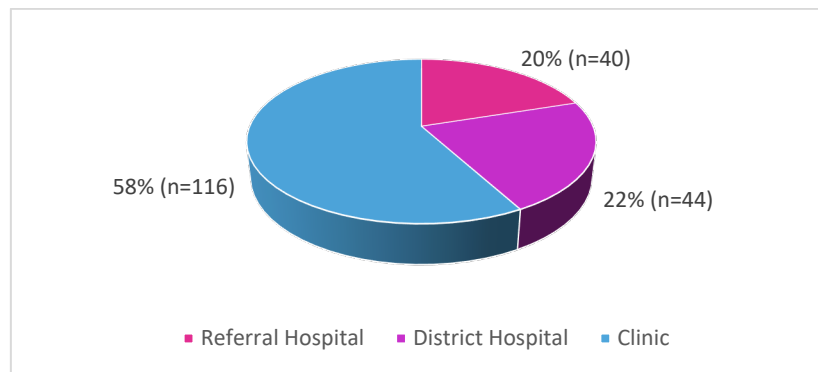
The results revealed that most of the respondents 36.5% (n=73) had been working in the same unit/ward for more than 5 years, whereas 8% (n=16) had been working there for less than 1 year. This result implies that working in one unit for more years might lead midwives to gain more experience, skills and knowledge in caring behaviour when nursing women during childbirth. Munabi-Babigumira *et al.*'s (2017:4) study found that amongst other factors, the number of years that a midwife worked in a particular setting led to accountability, responsibility, job performance and job satisfaction. This suggests that working in the same unit/ward for a long time might lead to caring behaviour in midwives.

The researcher, therefore, conducted Pearson's chi-squared test to investigate the relationship between the number of years working in the same unit/ward and caring behaviour towards women during childbirth. The p-value was 0.002, which was more than 0.05 and thus indicated that there was a statistically significant relationship between these two variables. Polit and Beck (2018:284), Maree (2016:229) and Burns and Grove (2015:30) maintain that when a p-value calculated by the test is less than 0.05, there is a significant association, and a p-value greater than 0.05 indicates that there is no significant association. Therefore, this research result shows that there was an association between working for longer years in the same unit/ward and the caring behaviour of the midwives under study and that experience, skills and knowledge led to caring behaviour.

#### 4.4.1.6 Work location

In this study, a work location was the area where the respondents were working in the maternity unit of the referral hospital, district hospital or clinic. Therefore, the respondents were asked to indicate their work location for the researcher to determine

whether it had any influence on their caring behaviour. Figure 4.6 below presents the results of the analysis of the data on the respondents' work location



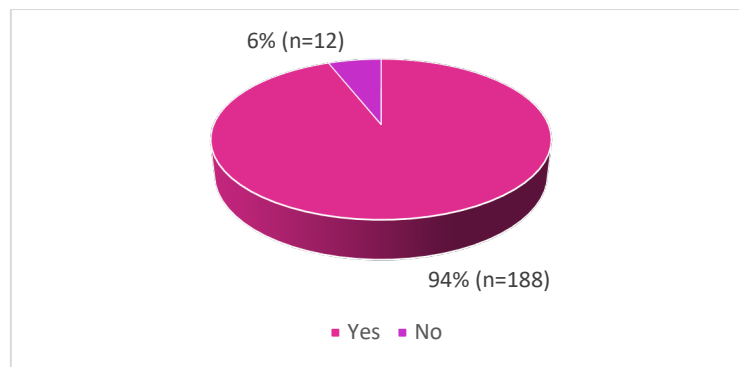
**Figure 4.6: Work location**

The results depicted in Figure 4.6 above showed that most of the respondents 58% (n=116) worked at local clinics. According to the Quality Health Standards of the Ministry of Health and Wellness (MoHW, 2013:2), most midwives are located in clinics dispersed across the various health districts of Botswana to minimise the distances travelled by women seeking maternal health care, which is the case internationally too (WHO, 2018:3; Larnsson & Hill, 2018:812; UNDP, n.d.). In addition, the literature indicates that more midwives work in local maternity clinics because they are located in rural areas (MoHW, 2011b).

The researcher investigated whether work allocation had an influence on the caring behaviour of midwives by running Pearson's chi-squared test. However, the p-value was 0.343, which meant that there was no statistically significant relationship between work location and midwives' caring behaviour. This result suggests that midwives' priority was to demonstrate caring behaviour regardless of their work location.

#### **4.4.1.7 Work satisfaction**

Work satisfaction in the study indicated whether the respondents felt fulfilled working in the maternity unit. The respondents were asked this question for the researcher to determine whether work satisfaction had a significant relationship with caring behaviour. Figure 4.7 below presents the results of the analysis of the data on the respondents' work satisfaction.



**Figure 4.7: Work satisfaction**

The results revealed that most of the respondents 94% (n=188) felt satisfied working in maternity wards. This result showed that midwives found pleasure in their work, which agrees with the results Mestdagh *et al.*'s (2019:1) and Peprah *et al.*'s (2018:66) studies, which found that most midwives enjoyed their jobs, which enhances their performance, commitment and stress-coping strategies.

Pearson's chi-squared test was performed to investigate whether there was a relationship between the respondents' job satisfaction and caring behaviour towards women during childbirth. The p-value was 0.001, which indicated that there was a statistically significant relationship between these two variables. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association.

The test result in the study suggested that the more a midwife is satisfied with his/her work, the more caring he/she is. This result was congruent with those of Weldearegay *et al.*'s (2020:18) and Lambert *et al.*'s (2018:260) studies, which revealed that a lack of job satisfaction due to work-related bottlenecks, such as a shortage of staff and burnout jeopardise midwives caring behaviour and compromise professional standards of care during childbirth.

#### **4.4.2 Section B: Respondents' responses to statements about midwives' caring behaviours**

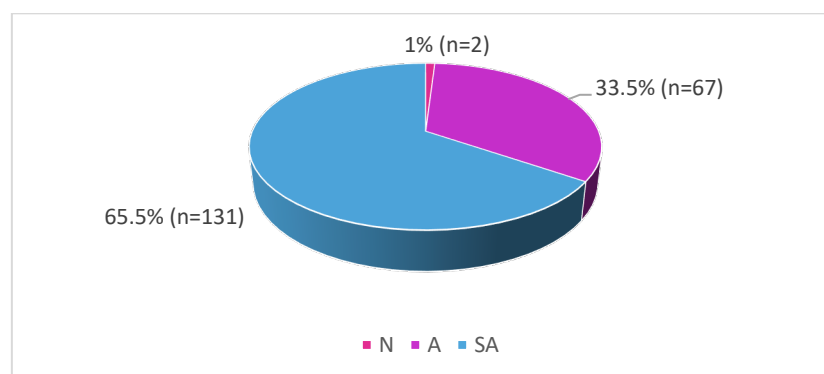
The results of the analysis of the data provided by the respondents' responses to the 21 statements about midwives' caring behaviour in Section B of the questionnaire would achieve the first research objective, which was to identify and describe the

caring behaviours of midwives who nurse women during childbirth in Botswana. Figures 4.8 to 4.27 below show the respondents' responses to statements about caring behaviours, which were measured according to a 5-point Likert scale from 1 to 5 ranging from Strongly Disagree to Strongly Agree. In the figures, SD = Strongly Disagree; D = Disagree; N = Neutral; A = Agree and SA = Strongly Agree.

As shown in the figures below, the respondents mostly agreed with statements B1 to B11, B13, B15, B17 and B19 to 21. However, mostly neutral responses were obtained for statements B12, B14, B16, and B18. The researcher, then, performed Pearson's chi-squared test to investigate whether there was a statistically significant relationship between each of the caring behaviour of midwives variables in Section B and the demographic variable of years of work experience as a midwife, which was Question A4 of Section A. Polit and Beck (2018:245), Burns and Grove (2015:30) and Maree (2016:229) maintain that when the p-value calculated by the test is less than 0.05, there is a significant association, and a p-value greater than 0.05 indicates that there is not a significant association. Based on the results and Swanson's (1991) Theory of Caring, recommendations will be made in Chapter 5 to midwives and unit managers that could be used to optimise the caring behaviour of midwives in Botswana.

#### 4.4.2.1 *Getting to know the woman*

Respondents were asked to indicate whether getting to know a woman who is in labour could be considered caring behaviour in a midwife. Figure 4.8 below shows the extent of the respondents' agreement that getting to know the patient is caring behaviour.



**Figure 4.8: Getting to know the woman**

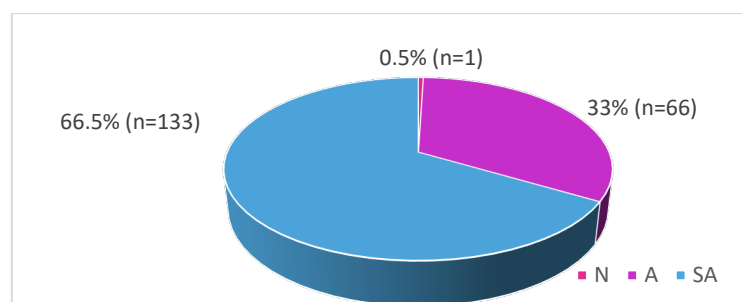
The results revealed that most of the respondents 99% (n=198) agreed that getting to know the woman is caring behaviour, and of that number, 65.5% (n=131) strongly

agreed with the statement, while only 1% (n=2) was neutral about this behaviour. Thus, the results indicated that midwives were aware that knowing and understanding the woman is a vital caring behaviour during childbirth. This outcome corroborates the WHO's (2018:3) statement that midwives need to establish a relationship of trust with the women and provide holistic sensitive, respectful and dignified care. It also supports the ICM (2018:195-200) emphasis on getting to know the woman as an essential responsibility in midwifery practice. Moreover, getting to know the women aligns with Swanson's (1991) Theory of Caring, which indicates caring as knowing, being with, doing for, enabling and maintaining belief (Swanson, 1991,1993,1999b).

Pearson's chi-squared test was performed to investigate whether there was a statistical relationship between getting to know the woman and years of work experience as a midwife. The p-value was 0.597, which indicated that there was no statistically significant association between these two variables. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The test result correlated with the ICM's (2018:195-200) statement that getting to know the woman is an essential responsibility in midwifery practice, but it does not depend on the number of years of work experience as a midwife.

#### 4.4.2.2 *Listening attentively to the woman when communicating*

Listening in a caring manner requires midwives to have the self-awareness and self-confidence to deliver honest, knowledgeable and safe care. Respondents were asked to indicate whether listening to the woman in labour when communicating was caring behaviour. Figure 4.9 below shows the analysis of the responses.



**Figure 4.9: Listening attentively to the woman when communicating**

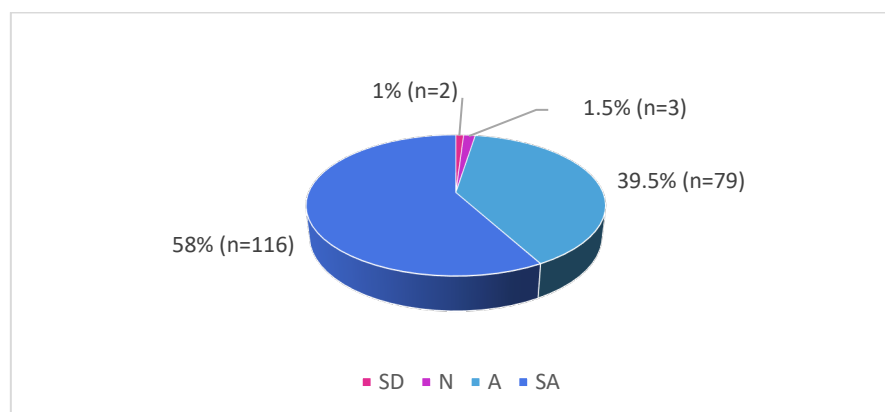
Most of the respondents 99.5% (n=199) understood that attentive listening was caring behaviour that enables midwives to know and explore more about the woman's needs. Midwives in this study believed that it is important to listen to what the women say. Generally, labouring women want their midwives to pay more attention to what they say because this helps them to feel safe and in control of the birth process.

This result is consistent with Khresheh *et al.*'s (2019:3) and Fontein-Kuiper *et al.*'s (2016:20) findings that listening attentively shows commitment, responsibility and concern for midwives about women's needs during childbirth.

Pearson's chi-squared test was performed to determine the relationship between listening attentively to the woman when communicating and years of work experience as a midwife. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The p-value was 0.539, which indicated that there was no statistically significant association between these variables.

#### 4.4.2.3 *Exploring the woman's needs*

Respondents were asked to indicate whether exploring a woman's needs is caring behaviour in midwives who nurse women during childbirth. Figure 4.10 below indicates the responses to the statement that exploring the labouring woman's needs is caring behaviour.



**Figure 4.10: Exploring the woman's needs**

The results indicated that most of the respondents 97.5% (n=195) considered exploring the labouring women's concerns as caring behaviour. Out of that number,

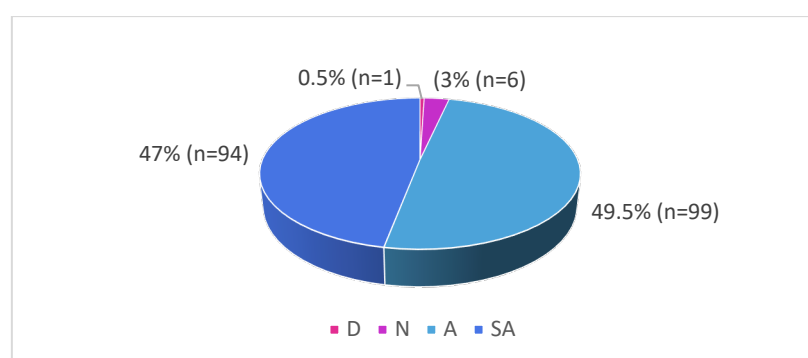


58% (n=116) strongly agreed with the statement. This result was congruent with Swanson's (1991:163;1993) Theory of Caring, which proposes that knowing a woman in labour enables a midwife to explore her needs adequately. This supports the results of the study conducted by Bradley *et al.* (2019:5), which revealed that the inability to meet a labouring woman's needs relegates her to the role of a bystander who does not know what is happening and thus demonstrates uncaring behaviour during childbirth.

Pearson's chi-squared test was performed between exploring woman's needs and years of work experience as a midwife. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when the p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The p-value was 0.036, which indicated that there was a statistically significant association between the two variables. The actual results show that midwives with years of work experience might have the skills to explore a women's needs during childbirth adequately.

#### 4.4.2.4 *Obtaining consent*

Respondents were asked to indicate whether obtaining consent was a characteristic of midwives' caring behaviour when nursing women during childbirth. Figure 4.11 below indicates the respondents' responses to the statement that obtaining consent was caring behaviour when nursing women during childbirth.



**Figure 4.11: Obtaining consent**

Figure 4.11 above shows that most of the respondents in the study 96.5% (n=193) agreed that obtaining consent was caring behaviour in midwives who nurse women during childbirth. Out of the recorded number, 47% (n=94) strongly agreed that

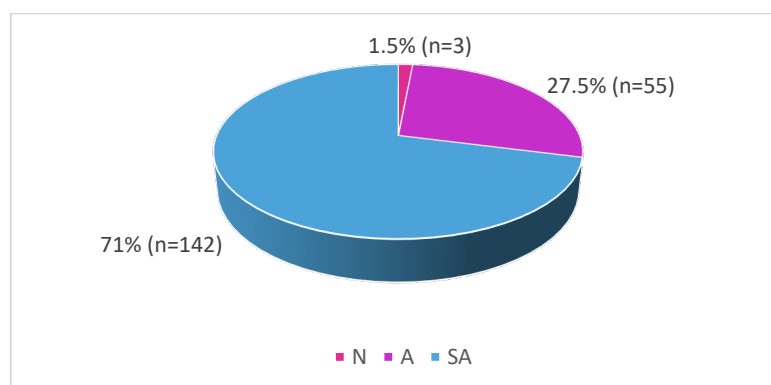
obtaining consent was caring behaviour and 49.5% (n=99) agreed. This result implied that generally, the midwives in the study were aware that they had to obtain consent from women for all the services that they provide during childbirth to ensure dignity and respect for their rights. The study results agree with the universal rights of childbearing women described by Bowser and Hill (2010:3-5), who maintain that every woman has a right to give informed consent for medical care and procedures offered during childbirth, such as a physical examination and an episiotomy.

Moreover, the WHO (2018:3) and Bohren *et al.* (2019:2) make intrapartum care recommendations for respectful maternal care for all women to ensure the maintenance of dignity, privacy, informed choice and continuous support during childbirth. Midwives in the study recognised that every woman has the right to receive the highest attainable standard of dignified and respectful care during childbirth.

Pearson's chi-squared test was performed between obtaining women's consent and years of work experience as a midwife. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The p-value was 0.650, which indicated that there was no statistically significant association between these two variables.

#### 4.4.2.5 *Being honest with the woman*

Respondents were asked to indicate whether being honest with a labouring woman is caring behaviour in midwives. Figure 4.12 below presents the respondents' responses to the statement that being honest with the labouring woman is caring behaviour.



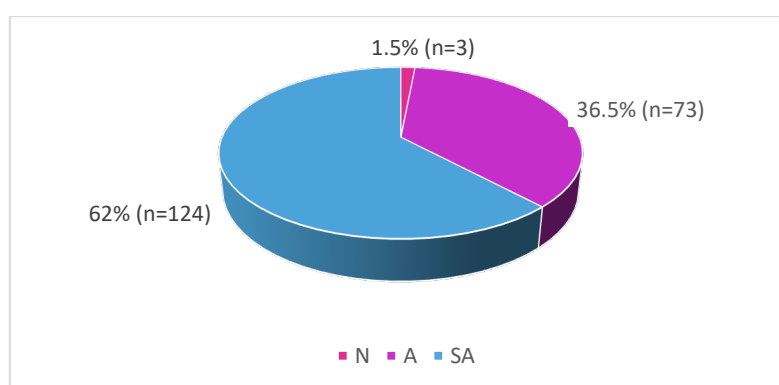
**Figure 4.12: Being honest with the woman**

Figure 4.12 above indicates that most of the respondents 98.5% (n=197) agreed that giving truthful information to a labouring woman about the childbirth process was caring behaviour, and of the recorded number, 71% (n=142) strongly agreed with the statement. This result confirms Bowser and Hill's (2010:3) work entitles *The Universal Rights of Childbearing Women*, which maintains that every woman has the right to receive truthful and honest information about their care during childbirth to enable the labouring her to cope with the birthing process.

Pearson's chi-squared test was performed to determine the relationship between being honest with the woman and the years of work experience as a midwife. Polit and Beck (2018:245). Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is no statistically significant association. The p-value was 0.166, which indicated that there was no statistically significant association between these variables.

#### 4.4.2.6 Ensuring confidentiality at all times

This statement was based on the maintenance of women's privacy. Respondents were asked to indicate whether ensuring confidentiality during childbirth was the caring behaviour of midwives. Figure 4.13 below is a breakdown of the respondents' responses to the statement that ensuring confidentiality during labour is caring behaviour.



**Figure 4.13: Ensuring confidentiality at all times while attending to the woman**

Figure 4.13 above indicates that most of the respondents 98.5% (n=197) agreed that always ensuring confidentiality while attending to a labouring woman is caring behaviour, and of the recorded number, 62% (n=124) strongly agreed. The study

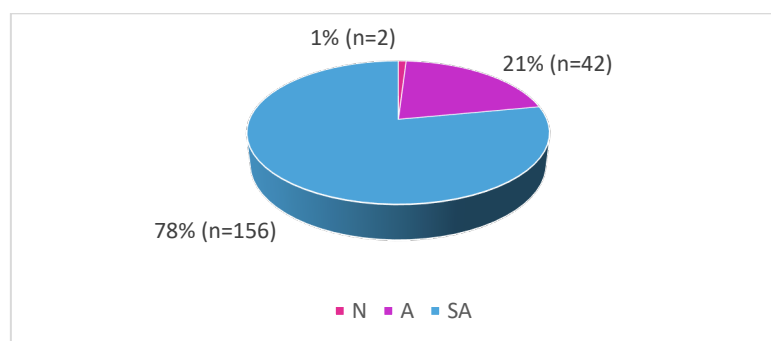
results indicated that midwives were aware that woman's privacy and confidentiality should be maintained during the birthing process. This result was consistent with the opinion of Bohren *et al.* (2019:2) and Bowser and Hill (2010:4) that every woman has the right to confidentiality during labour and childbirth.

Malatji and Madiba (2020:3) and Khresheh *et al.* (2019:3) maintain, however, that most women feel that midwives do not respect their privacy and ensure confidentiality. For example, vaginal examinations are often conducted in public in front of other labouring women. This action was considered uncaring behaviour and a violation of woman's rights during childbirth.

Pearson's chi-squared test was performed between the variable of ensuring confidentiality at all times during childbirth and the variable of years of work experience as a midwife. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The p-value was 0.200, which implied that there was no statistically significant association between the two variables. The test result indicated that the responsibility of midwives to ensure a woman's right to confidentiality and privacy during childbirth was not based on their years of work experience.

#### 4.4.2.7 Clear instructions

Respondents were asked to indicate whether clearly instructing women during childbirth is caring behaviour in midwives. Figure 4.14 below indicates the respondents' responses to the statement that giving clear instructions on what to do during childbirth is caring behaviour.



**Figure 4.14: Clear instructions**

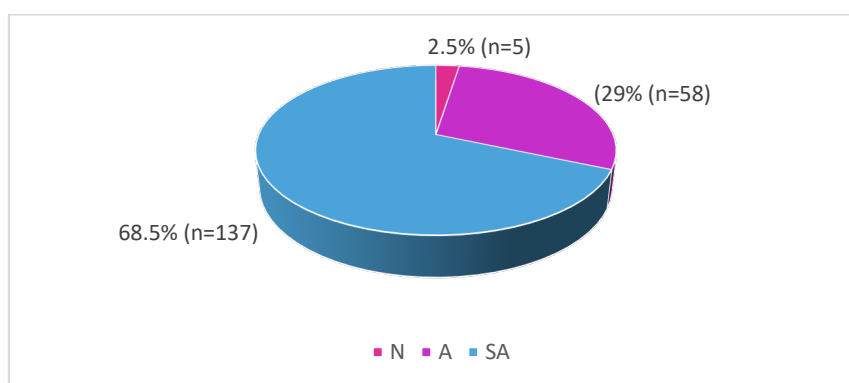
Nearly all the respondents 99% (n=198) agreed that giving clear instructions was caring behaviour, and of that number, 78% (n=156) strongly agreed with the statement. This result affirmed that the midwives in the study were mindful that sharing clear information with the women enables them to understand and abide by instructions given during childbirth. According to Swanson (1991:164;1999b), clearly explaining what to do, providing information and offering emotional support enable labouring women to cope during childbirth. As a result, the labouring women feel valued, respected and dignified. Therefore, the study results supported the literature cited above.

Similarly, the study results confirmed Weldearegay *et al.*'s (2020:16) and Rominski *et al.*'s (2017:222) views that the lived experience of care during childbirth includes effective communication and information-giving to ensure that every labouring woman and her family or relatives know what is happening, her rights and what to expect during childbirth.

Pearson's chi-squared test was performed to determine the relationship between giving clear instructions to the labouring woman and years of work experience as a midwife, which gave a p-value of 0.213. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The test indicated that there was no statistically significant association between these two variables.

#### 4.4.2.8 *Being authentically present during childbirth*

Being authentically present means being physically and emotionally available during childbirth. Respondents were asked to say whether they agreed with the statement that being authentically present during childbirth is caring behaviour. Figure 4.15 below indicates the responses to this statement.



**Figure 4.15: Being authentically present during childbirth**

The results in Figure 4.15 above show that 97.5% (n=195) of the respondents agreed that being authentically present during childbirth is caring behaviour, and of that number, 68.5% (n=137) strongly agreed with the statement.

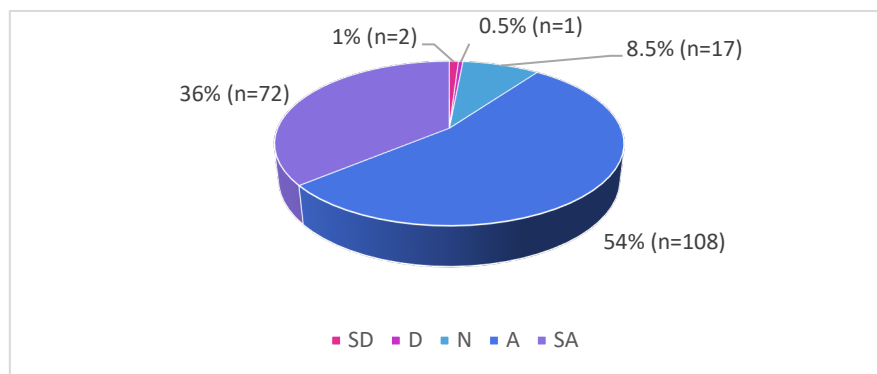
This result is in line with that of Khresheh *et al.*'s (2019:4) study that revealed that labouring women wanted their midwives to be present in the room when needed and to respond to them timeously, instead of ignoring their requests. Furthermore, Mårtensson *et al.* (2020:1125), Mårtensson *et al.* (2022:2) and Swanson (1991; 1993; 1999) maintain that continuous hands-on support during childbirth enables labouring women to manage it effectively.

Pearson's chi-squared test was performed to determine the relationship between midwives being authentically present during childbirth and years of work experience as a midwife, which resulted in a p-value of 0.394, which indicated no statistically significant association between the two variables. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The test result implied that the presence of midwives during childbirth enables them to respond

timeously to women's requests but is not related to the number of years of the midwives' experience.

#### 4.4.2.9 Putting the needs of the woman first

Respondents were asked to state whether putting the needs of the women in labour first before their own as caring behaviour in midwives. Figure 4.16 below summarises the responses to the statement that putting the needs of the woman first before those of the midwife is caring behaviour.



**Figure 4.16: Putting the needs of the woman first**

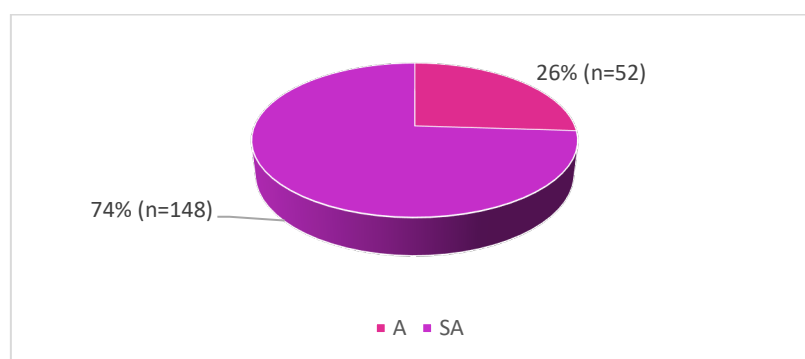
Figure 4.16 above shows that most of the respondents 90% (n=180) agreed that putting the needs of the woman first is caring behaviour, and of this number, 36% (n=72) strongly agreed with the statement. Thus, in the study, midwives were conscious that putting woman's needs before their own affirms caring behaviour.

These results were congruent with those of Ndwiga *et al.*'s (2017:6) and Larsson and Hill's (2018:812) studies that revealed putting the needs of the labouring woman first demonstrates kindness, commitment, friendliness and willingness to care for another with respect and dignity.

Pearson's chi-squared test was performed to determine the relationship between putting the needs of the woman first and years of work experience as a midwife. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is no statistically significant association. The p-value was 0.015, which indicated that there was a statistically significant association between midwives' years of work experience and commitment and willingness to put the needs of labouring women before their own.

#### 4.4.2.10 Keeping the woman informed about her progress

The respondents were asked to indicate whether keeping the labouring woman informed about her progress is caring behaviour. Figure 4.17 below represents the respondents' responses to the statement that keeping the woman informed about her progress is caring behaviour.



**Figure 4.17: Keeping the woman informed about her progress**

Figure 4.17 above shows that all the respondents 100% (n=200) agreed that keeping the labouring woman informed about her progress is caring behaviour, and of this number, 74% (n=148) strongly agreed with the statement.

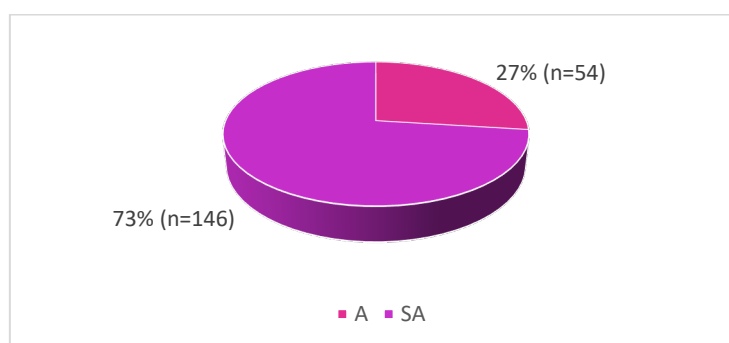
This result is in line with Anderson *et al.*'s (2020:14) and Khresheh *et al.*'s (2019:1) opinions that midwives who frequently inform labouring women about the progress of their labour, alleviate anxiety. Again, this shows commitment and willingness to create a calm environment, hope and positivity during childbirth. The result of the current study suggests that the midwives were aware that keeping a labouring woman informed about her progress alleviates her anxiety and enhances a calm environment during childbirth.

Pearson's chi-square test was performed to investigate whether there was a relationship between keeping the woman informed about her progress and years of work experience as a midwife. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The result was a p-value of 0.542, which showed show that there was no statistically significant association between these two variables.



#### 4.4.2.11 Giving reassurance about the childbirth process

Respondents were asked to state whether giving women reassurance about the childbirth process is caring behaviour during childbirth. Figure 4.18 below represents the respondents' responses to the statement that giving reassurance about the childbirth process is caring behaviour.



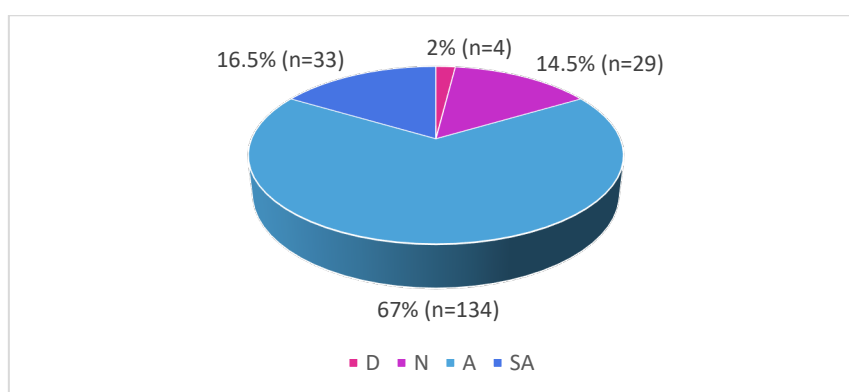
**Figure 4.18: Giving reassurance about childbirth progress**

Figure 4.18 above indicates that all the respondents 100% (n=200) agreed that giving reassurance about the childbirth process is caring behaviour, and of that number, 73.0% (n=146) strongly agreed with the statement. Moreover, this result agreed with the outcomes of Anderson *et al.*'s; (2020:14) and Maputle's (2018:4) studies that found that women wanted to be periodically informed about their labour progress, and their foetus's wellbeing to alleviate anxiety. The result of the current study suggests that midwives were mindful of sustaining labouring women's faith in their ability to manage childbirth and face the future with meaning.

Pearson's chi-squared test was performed to determine the relationship between giving reassurance about childbirth progress and years of work experience as a midwife. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The p-value was 0.293, which revealed that there was no statistically significant association between these variables.

#### 4.4.2.12 *Arranging for the woman to see her relatives*

Respondents were asked to state whether arranging for the labouring woman to see her relatives was caring behaviour. Figure 4.19 below represents the respondents' responses to the statement.



**Figure 4.19: Arranging for the woman to see her relatives**

Figure 4.19 above shows that the majority of respondents 83.5% (n=167) agreed that arranging for the labouring woman to see her relatives is caring behaviour. Of the above number, 16.5% (n=33) strongly agreed with the statement. This result implied that the midwives considered doing for others what they would do for themselves, such as arranging for a woman in labour to see her relatives as caring behaviour.

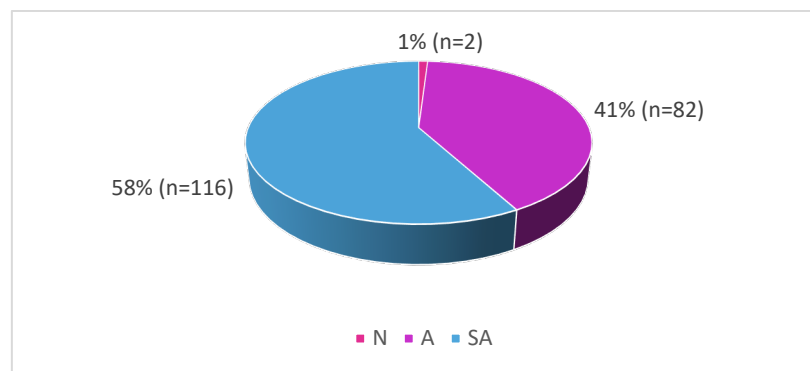
Swanson (1991:164; 1999b) maintains that what she terms “doing for others” is caring behaviour that alleviates a woman’s anxiety and fear about giving birth and enables her to manage the childbirth process with determination. This result showed that the midwives in the study were cognisant of alleviating labouring women’s fear and anxiety, by making provisions for relatives to see their family members at scheduled visiting hours. In addition, midwives were aware that they had to make arrangements for those women who were unable to meet their relatives at a visiting bay, allowing them to see the women at their bedsides.

Pearson’s chi-squared test investigated the relationship between the variable of arranging for the labouring woman to see her relatives and the variable of years of work experience as a midwife. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that

there is a statistically insignificant association. The p-value was 0.307. The test results were statistically insignificant association.

#### 4.4.2.13 *Providing privacy for the woman*

Respondents were asked to indicate whether providing privacy for the woman was the caring behaviour of midwives. Figure 4.19 below represents the respondents' responses to the statement that providing privacy for the labouring woman is caring behaviour.



**Figure 4.20: Providing privacy for the woman**

Figure 4.20 above shows that almost all the respondents 99% (n=198) agreed that providing privacy for the woman is caring behaviour, and of that number, 58% (n=116) strongly agreed.

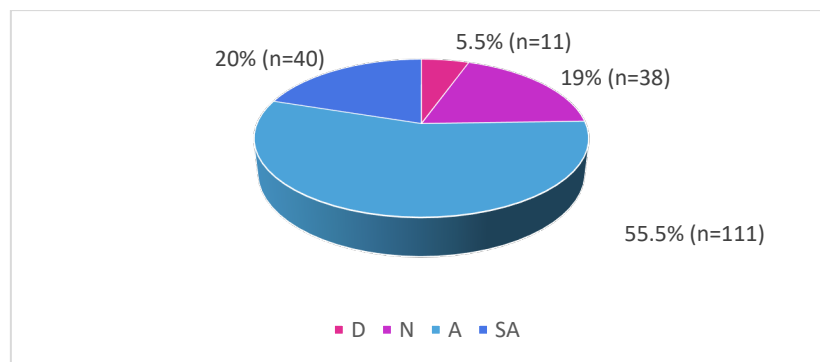
Mayra, Matthews and Padmadas (2020:6) and Anderson *et al.* (2020:11) found in their studies that maintaining privacy during childbirth meant that women felt protected. Furthermore, Bowser and Hill (2010:4) point out that one of the principles of maternal health care is the right to privacy and confidentiality. Moreover, the study corroborated the literature that maintains that maintaining privacy is caring behaviour during childbirth.

Pearson's chi-squared test determined whether there was a relationship between the variable of privacy for a woman in labour and the variable of years of work experience as a midwife. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The results showed a p-value of 0.184, which

indicated that there was no statistically significant association between these two variables.

#### 4.4.2.14 *Respecting the woman's preferences*

Respondents were asked to indicate whether respecting women's preferences is a caring behaviour in midwives. Figure 4.21 below represents the respondents' responses to the statement that respecting the woman's preferences is caring behaviour.



**Figure 4.21: Respecting the woman's preferences**

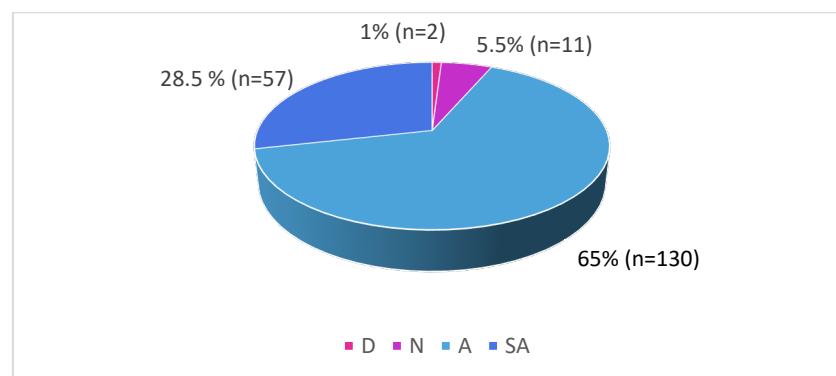
Figure 4.21 above indicates that more than half of the respondents 55.5% (n=111) agreed, and 20% (n=40) strongly agreed that respecting the labouring woman's preferences is caring behaviour. However, 19% (n=38) were neutral, which might be because they were uncertain about their preferences or labouring women did not express their preferences and complied with what midwives instructed them to do. This result indicated that the midwives in the study were cognisant that women's choices and preferences should be respected to ensure a comfortable and dignified birthing process.

Khresheh *et al.* (2019:3) maintain that labouring women need midwives to pay attention to what they prefer to feel comfortable, safe and in control of the birth process. In addition, Al-Maharma *et al.*'s (2021:1) and McMahon *et al.*'s (2018:2) studies indicated that respecting women's preferences and choices and meeting their needs and expectations help them to achieve satisfying births and thus improve their health and well-being. Thus, the study results were congruent with the literature indicating that respecting a labouring woman's preferences is the caring behaviour of midwives.

Pearson's chi-squared test was performed to investigate whether there was a relationship between respecting woman's preferences and the years of work experience as a midwife. Polit and Beck (2018:245); Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The result was a p-value of 0.395. These test results imply that there were no statistically significant associations between this variable.

#### 4.4.2.15 *Sharing the responsibility with the woman*

Respondents were asked to indicate whether sharing responsibility with the woman is a characteristic of the caring behaviour of midwives who nurse women during childbirth. Figure 4.22 below represents the respondents' responses to the statement that sharing the responsibility with the woman is caring behaviour.



**Figure 4.22: Sharing responsibility with the woman**

Figure 4.22 above reveals that most of the respondents 93.5% (n=187) agreed that sharing the responsibility with the labouring women is caring behaviour, and of that number, 65% (n=130) strongly agreed. Sharing responsibility with the woman builds the woman's self-confidence and determination

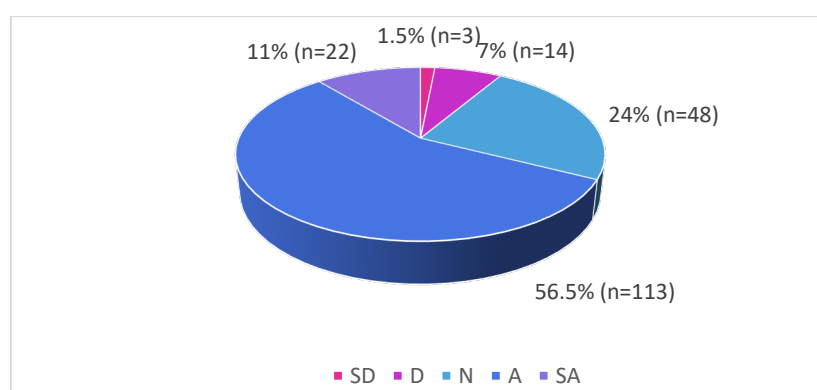
Swanson (1991:165;1993) maintains that sharing the responsibility encourages women's ability to face childbirth with trust and the hope that they will achieve the childbirth process effectively. Similarly, Mayra *et al.* (2020:8) and Bradley *et al.*'s (2019:2) studies indicated that involving women in caring during childbirth strengthens their ability to achieve their expectations.

Moreover, Mestdagh *et al.* (2019:1); Lohmann *et al.* (2018:58) and Ndwiga *et al.* (2017:8) studies indicated that women wanted midwives to involve in policymaking as the two key stakeholders in maternal health care. Moreover, the literature supports the current study's results that midwives demonstrated a willingness in sharing power and feelings with the women in an understanding way that facilitated mutuality. The above-mentioned authors define mutuality as accepting assistance or support from one another

Pearson's chi-squared test was performed between sharing the responsibility with the woman and years of work experience as a midwife. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The p-value was 0.000, which meant that there was a statistically significant association between the variables and that sharing responsibility with women in labour is enhanced by the years of work experience gained by the midwife when nursing women during childbirth.

#### 4.4.2.16 *Keeping relatives informed about the woman*

Respondents were asked to indicate whether keeping relatives informed about the woman in labour was caring behaviour on the part of midwives. Figure 4.23 below shows the breakdown of the respondents' responses to the statement that keeping relatives informed about the woman in labour is caring behaviour.



**Figure 4.23: Keeping relatives informed about the woman**

Figure 4.23 above shows that more than half of the respondents 67.5% (n=135) indicated that keeping relatives informed about the woman is caring behaviour. Of that number 56.5% (n=113) agreed with the statement, while 24% (n=48) were neutral.

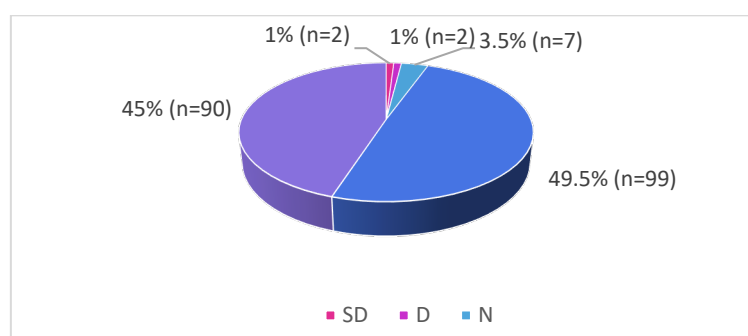
The results suggested that the midwives in the study were aware that their caring behaviour should not only be confined to the labouring woman. The relatives also deserve to be treated with compassion, respect and dignity.

Kalocsai *et al.* (2018:4) point out that family members prefer to be involved in the delivery of care and the decision-making process about the labouring woman's care in the maternity care unit. Thus, the literature supports the study's result that relatives play a significant role in the birthing process. However, the fairly large number of neutral and negative responses suggest that this caring behaviour is not always demonstrated in maternity care units, which will be discussed in the recommendations presented in Chapter 5.

Pearson's chi-squared test was performed to investigate the association between keeping relatives informed about the woman and her years of work experience as a midwife. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The p-value was 0.017, which indicated that there was a statistically significant association between these two variables. Thus, the test results showed that involving and accepting the woman's relatives' support during childbirth is influenced by the number of years of work experience of the midwives.

#### 4.4.2.17 Showing genuine interest

Respondents were asked to indicate whether showing genuine interest in caring behaviour in midwives who nurse women during childbirth. Figure 4.24 below summarises the respondents' responses to the statement that showing genuine interest is caring behaviour.



**Figure 4.24: Showing genuine interest**

Figure 4.24 above shows that most of the respondents 94.5% (n=189) agreed that showing genuine interest was caring behaviour, and of that number, 49% (n=90) strongly agreed with the statement. These results indicate that the midwives in the study were mindful that showing labouring women their willingness and interest motivates them to face childbirth with confidence.

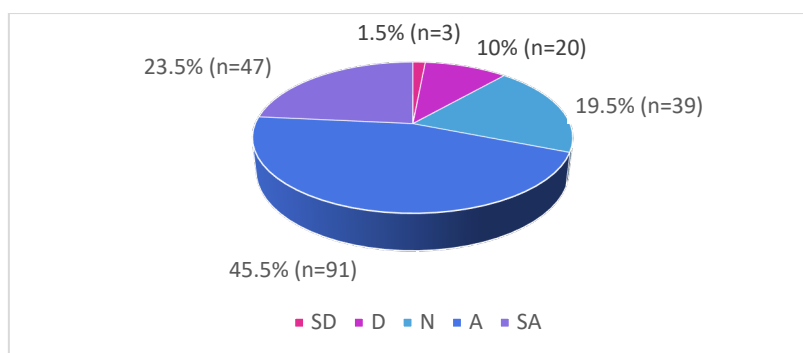
Swanson (1991) and Bradley *et al.* (2019:2) find that showing genuine interest is a key element of willingness to provide holistic care that addresses the psycho-social needs of women during childbirth. Moreover, Turkel *et al.* (2018:66-67) maintain that showing genuine interest indicates kindness and respect. This literature corroborates with the study results, that showing genuine interest is a significant characteristic of the caring behaviour of midwives who nurse women during childbirth.

Pearson's chi-squared test between showing a woman's genuine interest during childbirth and years of work experience as a midwife was investigated. Polit and Beck (2018:245); Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The p-value was 0.002, which indicated a statistically significant association between these variables and that the years of work experience as a midwife has a positive impact on labouring women's experience of the birthing process.

#### *4.4.2.18 Staying at work to complete a job after the shift has ended*

In this statement, respondents were asked to indicate whether carrying out care after the shift has ended was caring behaviour in midwives. Figure 4.25 below reflects the respondents' responses to the statement that carrying out care after the shift has ended was caring behaviour.





**Figure 4.25: Staying at work to complete a job after the shift has ended**

Figure 4.25 above shows that the majority of respondents 69% (n=138) reported that continuity of care after the shift has ended is caring behaviour, and out of the reported number, 23.5% (n=47) strongly agreed with the statement. These results imply that the midwives in the study were cognisant of their presence beyond their routine work scheduled time, ensuring that the labouring woman received quality and dignified care until the end of the childbirth process. However, a significant number of respondents 19.5% (n=39) were neutral to the statement responses, which suggests room for further research.

Swanson (1991:164;1993) indicates that being with labouring women makes them feel honoured, valued, relieved and comforted because they know that the midwife is there for them. In addition, Anderson *et al.* (2020:14) and Mårtensson *et al.* (2020:1125) maintain that women want midwives who care for and support them during the long hours of labour right until the end, which indicates bonding and attachment. Thus, the literature was congruent with the study's result, which showed that the midwives in the study were probably physically available and mindfully present for the labouring women in their care by conveying intimate caring support, ensuring that a labouring woman received cared with respect, dignity and going beyond their routine work scheduled.

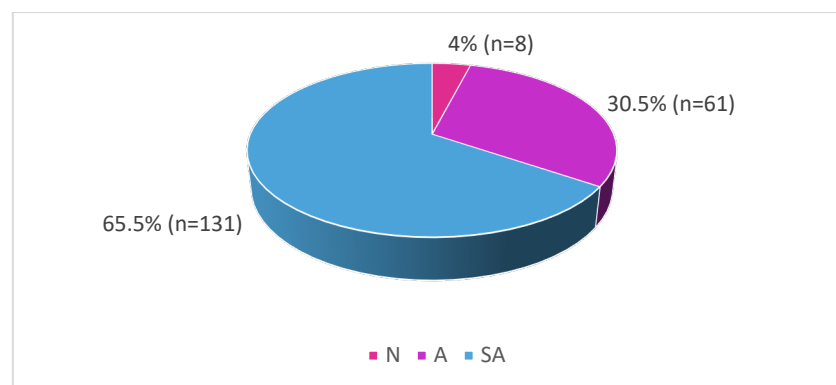
The results of the current study corroborated those of Larsson and Hill's (2018:812) study, which described the caring patterns of midwives for whom midwifery care was not limited to time. For these midwives, there were no regulated working hours, and they were available 24 hours a day, 7 days a week. The midwifery profession was a service in the sense that midwives put their own convenience aside, thereby going the extra mile and conveying continuous support to the labouring women after the shift

has ended. However, the statement received several negative responses, which could be due to the respondents feeling that exhaustion could be a problem if midwives were expected to continue with a shift after it has ended owing to a shortage of staff.

Pearson's chi-squared test was performed to determine the relationship between staying at work to complete a job after the shift has ended and the number of years of work experience as a midwife. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The p-value was 0.020, which indicated a statistically significant association and that midwives with several years of work experience were willing to stay at the work to complete a job after the shift had ended.

#### 4.4.2.19 *Showing professional intimacy*

Respondents had to indicate whether showing professional intimacy with a labouring woman was caring behaviour. Figure 4.26 below is a summary of how respondents responded to the statement that showing professional intimacy is caring behaviour.



**Figure 4.26: Showing professional intimacy**

Figure 4.26 above shows that almost all the respondents 96% (n=192) agreed that showing professional intimacy was caring behaviour, and of that number, 65.5% (n=131) strongly agreed with the statement. These results showed that the midwives in the study were aware that they were obliged to show be close to patients professionally when caring for women during childbirth.

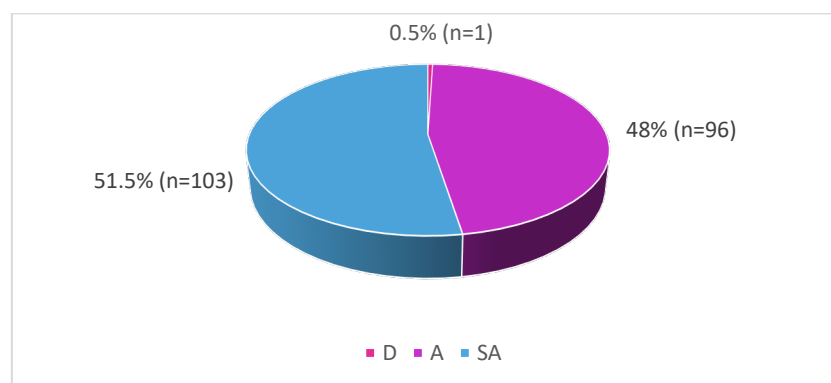
According to Cherry (2018:1-2) and Rominski *et al.* (2017:6), caring involves unique, dynamic feelings, thoughts and concerns that shape/guide a person's caring

behaviour and drive midwives to care for women with respect for their dignity. Bohren *et al.* (2019:6) indicate that most often, women reveal a need for respectful closeness not just as women in labour but also as human beings with the right to dignified and respectful friendship during childbirth. Therefore, the study results revealed that many midwives were aware of the professional standards of care to which they should adhere whereby they demonstrate interpersonal sensitivity and recognise that labouring women are autonomous agents but need close and warm contact during labour.

Pearson's chi-squared test was performed to determine the association between showing professional intimacy and years of work experience as a midwife. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The p-value was 0.343, which indicated an insignificant statistical association between these two variables.

#### 4.4.2.20 *Creating a calm atmosphere*

In the study, creating a calm atmosphere meant establishing a comfortable and welcoming environment. Respondents were asked to indicate whether creating a calm atmosphere was caring behaviour during childbirth. Figure 4.27 below presents the respondents' responses to the statement that creating a calm atmosphere is caring behaviour.



**Figure 4.27: Creating a calm atmosphere**

Figure 4.27 above shows that almost all the respondents 99.5% (n=199) reported that creating a calm atmosphere was caring behaviour, and of that number, 51.5% (n=103)

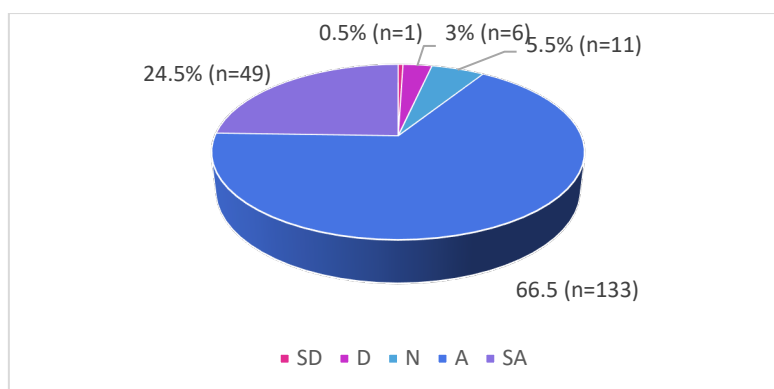
strongly agreed with the statement. The results indicated that the midwives in the study were conscious that women need a comfortable environment during childbirth.

The study results were congruent with Swanson's (1991;1993,1999b) and Watson's (2008) theories, which emphasise that creating a calm atmosphere during childbirth potentiates healing and enables the labouring woman to face the childbirth process with hope and determination. Moreover, Al-Maharma *et al.* (2021:2); Khresheh *et al.* (2019:70) and Larsson and Hill (2018: 814) emphasise that there should be calm when communicating with women to establish a trusting relationship and ideal birthing environment. A calm atmosphere enhances interpersonal interaction that encourages emotional attachment and openness. Therefore, midwives should establish a relationship of trust with their patients through bonding to establish a conducive, dignified and respectful birthing environment. The results showed that the midwives in the study displayed caring behaviour that embraced human dignity, thereby enabling the labouring woman to feel comfortable during childbirth.

Pearson's chi-squared test determined the relationship between creating a calm atmosphere and years of work experience. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The p-value was 0.154, which shows that there was no statistically significant association.

#### *4.4.2.21 Attending to the labouring woman's demanding needs*

Respondents were asked to describe whether attending to the labouring women's demanding needs was caring behaviour. Figure 4.28 below indicates how the respondents responded to the statement that attending to the labouring woman's demanding needs is caring behaviour.



**Figure 4.28: Attending to the labouring woman's demanding needs**

Figure 4.28 above shows that the majority of the respondents 91% (n=182) agreed that attending to the labouring woman's demanding needs is caring behaviour in midwives who nurse women during childbirth, and of this number, 24.5% (n=49) strongly agreed. The results showed that the midwives in the study were aware that attending to the women's demanding needs showed willingness and commitment to care during childbirth.

A study conducted by Fontein-Kuipers *et al.* (2018:1-3) found that satisfying the labouring women's demanding needs indicated a collaboration between them and midwives, who are compelled to understand their needs. Moreover, according to Anderson *et al.* (2021:7), through their constant utilisation of their knowledge and skills, midwives maintain a hope-filled attitude during childbirth. For example, many midwives demonstrate a willingness to support labouring women's demanding needs by giving them a back rub, allowing a birth companion in the delivery room and permitting relatives after visiting hours.

Pearson's chi-squared test was used to determine the relationship between attending to the labouring woman's demanding needs and years of work experience as a midwife. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The results showed a p-value of 0.342, which indicated a statistically insignificant association.

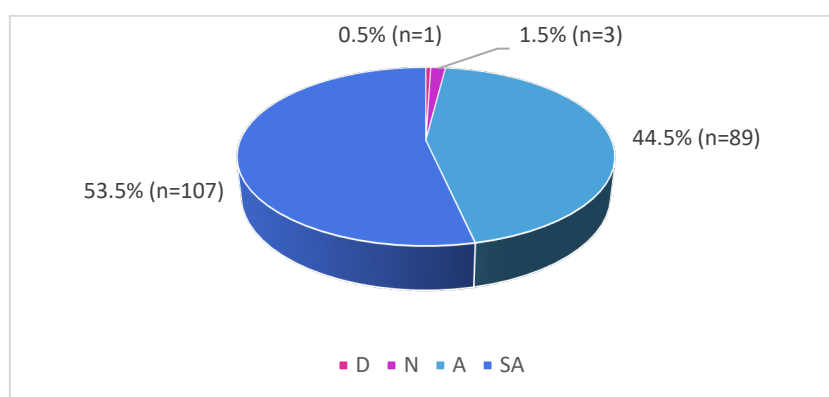
#### **4.4.3 Section C: Respondents' responses to statements about inhibiting factors affecting midwives' caring behaviour**

The results of the analysis of the data provided by the respondents' responses to the statements about the inhibiting factors affecting the caring behaviour of midwives in Botswana are presented in this section. Figures 4.29 to 4.50 below show the respondents' responses to the statements, which were measured according to a 5-point Likert scale from 1 to 5 ranging from Strongly Disagree to Strongly Agree. SD = Strongly Disagree; D = Disagree; N = Neutral; A = Agree and SA = Strongly Agree.

Moreover, Pearson's chi-squared tests were performed to investigate the association between the variables of the inhibiting factors and years of work experience (Polit & Beck, 2018:245; Fain, 2017:284) indicated by p-values. A p-value less than 0.05 indicates a statistically significant association and a p-value greater than 0.05 indicates that there is an insignificant association.

##### **4.4.3.1 Shortage of staff**

Some studies identify a shortage of staff as one of the reported major bottlenecks in the caring behaviour of midwives when nursing women during childbirth. Respondents were asked to indicate whether this is an inhibiting factor affecting caring midwives' caring behaviour.



**Figure 4.29: Shortage of staff**

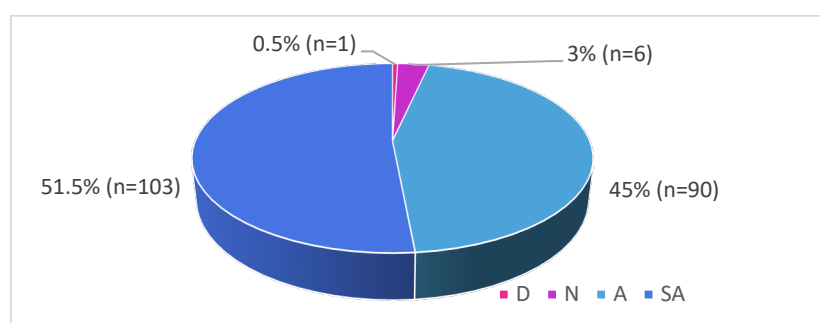
Figure 4.29 above shows that the majority of the respondents 98% (n=196) agreed that a shortage of staff inhibits caring behaviour in midwives, and of that number, 53.5% (n=107) strongly agreed with the statement. The study results showed that midwives in the study identified that a shortage of staff was an inhibiting factor when nursing women during childbirth.

According to Mayra *et al.* (2022:6); Weldearegay *et al.* (2020:15) and Munabi-Babigumira *et al.* (2017:15), the provision of intrapartum and postpartum care in low- and middle-income countries are negatively affected by a shortage of staff and a heavy workload, which make midwives angry and frustrated, as they are overburdened and therefore they are unable to provide quality maternal health care to meet women's expectations and needs. The literature supports the results of the current study, as it shows that a shortage of staff is an inhibiting factor affecting the caring behaviour of midwives when nursing women during childbirth.

The researcher performed Pearson's chi-squared test to determine the relationship between a shortage of staff and years of work experience as a midwife. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The p-value was 0.000, which indicated that there was a statistically significant association. Therefore, the effects of a shortage of staff may depend on the work experience of a midwife.

#### 4.4.3.2 Work overload

Respondents were asked to indicate whether the workload is a factor inhibiting their caring behaviour. Figure 4.30 below indicates whether work overload was identified as an inhibiting factor affecting midwives' caring behaviour.



**Figure 4.30: Work overload**

Figure 4.30 above reveals that most of the respondents 96.5% (n=193) strongly agreed that work overload inhibits caring behaviour in midwives. Of this number, 51.5% (n=103) strongly agreed with the statement. This result supports those of the studies conducted by Lappeman and Swartz (2019:11), Bohren *et al.* (2019:1) and Ndwiga *et*

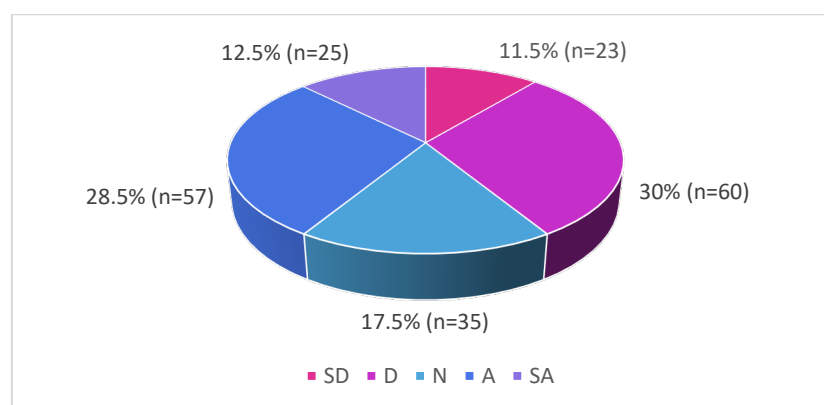
*al.* (2017:10), which demonstrated that uncaring behaviour often stems from a heavy workload, inadequate staffing rate, unfavourable work conditions, frustration and burn-out, which inhibit quality and respectful care.

A heavy workload often means that labouring women wait longer to receive care and thus feel neglected and abandoned by their midwives. The results seem to correlate with the actual situations that the more the employee is satisfied the more the productivity, and the less the enabling working environment the less the productivity. In addition, the results were similar to those of Weldearegay *et al.*'s (2020:18) and Lambert *et al.*'s (2018:260) studies, which revealed that work-related bottlenecks, such as shortage of staff, work overload and burnout led to the failure of midwives to meet professional standards of care during childbirth.

Pearson's chi-squared test determined the relationship between midwives' work overload and years of work experience as a midwife variable. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The results showed a p-value of 0.000, which indicated that there was a statistically significant association, thereby indicating that work overload might impact midwives' quality of care depending on their lack of work experience.

#### 4.4.3.3 *Poor teamwork*

In the study, respondents were asked to indicate whether poor teamwork is an inhibiting factor affecting the caring behaviour of midwives during childbirth. Figure 4.31 below indicates whether poor teamwork was identified by the respondents as an inhibiting factor.



**Figure 4.31: Poor teamwork**



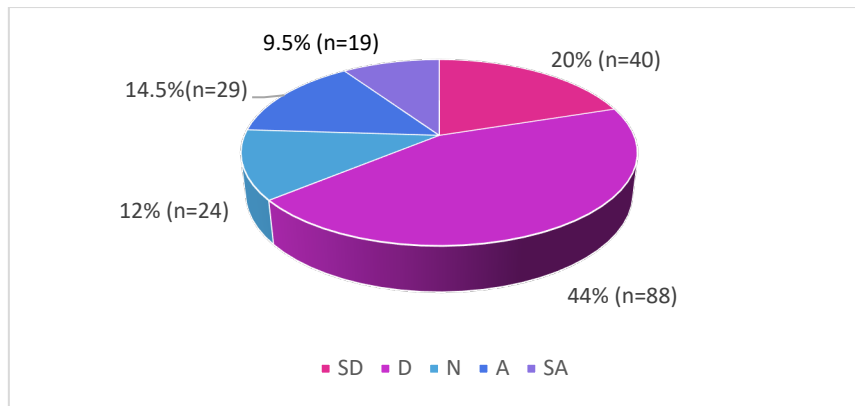
Figure 4.31 above shows that of all the respondents 41.5% (n=83) reported that poor teamwork does not affect the caring behaviour of midwives when nursing women during childbirth. Of this number, 30% (n=60) disagreed with the statement. However, almost the same number of respondents (41%, n=82) agreed with the statement that poor teamwork was an inhibiting factor. The differences in the results might have been due to various factors, such as the number of years of experience as a midwife in the ward/unit or different experiences at the workplace, which might have led to the respondents having different opinions.

The differences in the study results might also be explained in part by Dzomeku *et al.*'s (2018:3) and Lori *et al.*'s (2018:3) studies, which indicated that caring behaviour might not depend on work situations, such as poor teamwork. This means that women-centred care is a vital aspect of midwifery practice whereby women should not be deprived of quality care because of the complexity of the work environment.

Pearson's chi-squared test was performed to determine the relationship between poor teamwork and years of work experience as a midwife. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The p-value was 0.102, which indicated a statistically insignificant relationship, thereby indicating that midwives' years of experience would have no impact on how they experience teamwork.

#### 4.4.3.4 *Absenteeism*

Respondents were asked to indicate whether absenteeism is a factor inhibiting the caring behaviour of midwives. Figure 4.32 below indicates what the respondents thought.



**Figure 4.32: Absenteeism**

Figure 4.32 above shows that most of the respondents 64% (n=128) reported that absenteeism did not inhibit the caring behaviour of midwives who nurse women during childbirth. Of that number, 44% (n=88) disagreed with the statement. These results show that the midwives in the study most ranked woman's needs and expectations enough not to be absent. In addition, the results corroborate those of Al-Maharma *et al.*'s (2021:6) and Dzomeku *et al.*'s (2018:3) studies, which recommended that midwives provide woman-centred care that is respectful and responsive to their needs and expectations as cornerstone for achieving women's satisfaction during their childbirth experience. The current study results, therefore, explain that midwives should not deprive women of optimal care during childbirth, irrespective of the challenges in their workplace.

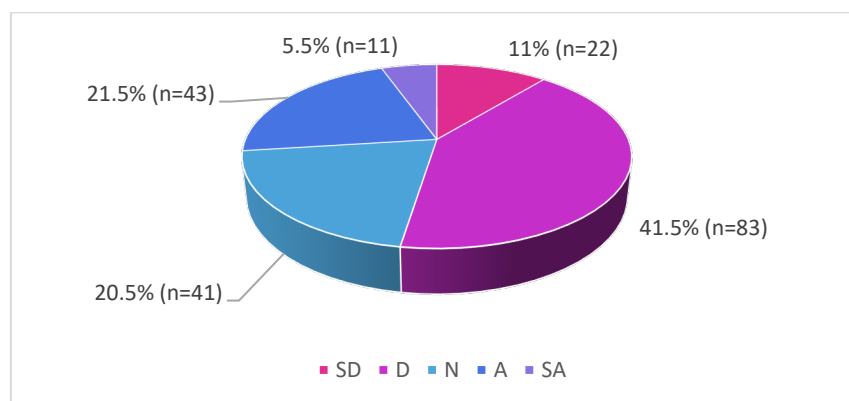
In contrast, absenteeism was indicated by 24% of the respondents (n=48) who agreed with the statement, which was congruent with the results of Ndwiga *et al.*'s (2017:11) and Mannava *et al.*'s (2015:7-8) studies, which found that absenteeism was frequently a factor inhibiting the caring behaviour of midwives reported in 33 studies conducted in Africa. Therefore, the literature affirms that an unfavourable work environment often impacts midwives' abilities to deliver optimal care during childbirth.

Pearson's chi-squared test was performed to determine the relationship between absenteeism and years of work experience as a midwife. Polit and Beck (2018:245); Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The p-value was 0.001, indicating a statistically significant association between these two

variables. These test results correlate with literature that absenteeism leads to a shortage of staff, which in turn results in work overload, frustration and burnout. Hence, absenteeism may inhibit the caring behaviour of midwives depending on the number of years of their work experience.

#### 4.4.3.5 *Poor collaboration with colleagues*

Poor collaboration means poor team working. Respondents were asked to indicate whether poor collaboration with colleagues is an inhibiting factor affecting the caring behaviour of midwives. Figure 4.33 below indicates what the respondents reported.



**Figure 4.33: Poor collaboration with colleagues**

Figure 4.33 above shows that many of the respondents 52.5% (n=105) disagreed that poor collaboration with colleagues was a factor inhibiting the caring behaviour of midwives during childbirth. Of this number, 11% (n=22) strongly disagreed with the statement. Thus, the results revealed that poor collaboration with colleagues was not an inhibiting factor in the caring behaviour of midwives when nursing women during childbirth.

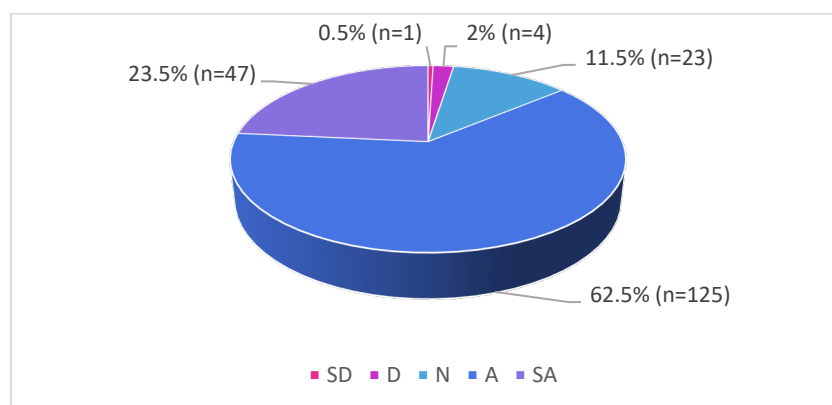
Munabi-Babigumira *et al.* (2017:16), however, maintain that a poor attitude and unethical behaviour amongst midwives towards each other could influence the quality of the care women receive from midwives during childbirth. Moreover, Bradley *et al.*, (2019:3) and Maputle (2018;10) indicate that poor interaction between midwives could create tension, poor teamwork, and significant burnout and moral distress, which might threaten the relationship between midwives and women. However, midwives are obliged to provide the highest standard of maternal care to labouring women despite their work complexity. Nevertheless, the study's results did not corroborate with these

literature findings, and poor collaboration with colleagues was not identified as an inhibiting factor in their caring behaviour during childbirth.

Pearson's chi-squared test was performed to determine the relationship between poor collaboration with colleagues and years of work experience as a midwife. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The test resulted in a p-value of 0.000, indicating a statistically significant relationship between these two variables. The test correlates with the literature that maintains that poor collaboration with colleagues could depend on the number of years of a midwife's work experience.

#### 4.4.3.6 *Poor work environment*

A poor work environment is an uncomfortable working place. Respondents were asked to indicate whether a poor working environment is a factor inhibiting factor their caring behaviour during childbirth. Figure 4.34 below indicates whether a poor work environment was identified by the respondents as an inhibiting factor in midwives' caring behaviour.



**Figure 4.34: Poor work environment**

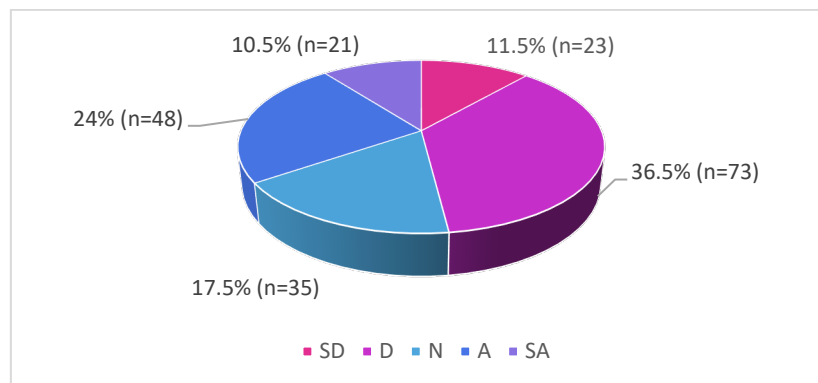
Figure 4.34 above reveals that 86% of the respondents (n=172) identified a poor working environment as an inhibiting factor, and of this number 23.5% (n=47) strongly agreed. The results clearly explained that the midwives in the study felt that unfavourable work environment constrained their caring behaviour during childbirth. This conforms to the results of Bradley *et al.*'s (2019:3); Munabi-Babigumira *et al.*'s (2017:16) and Ndwiga *et al.*'s (2017:8-11) studies, which indicated that the work

environment plays a significant role in shaping health providers' ability to promote respectful maternity care. In addition, the current study's results confirm those of the studies conducted by John *et al.* (2020:168); Bohren *et al.* (2019:1756); Shallow *et al.* (2018:1) and Munabi-Babigumira *et al.* (2017:4), which claim that holistic care is inhibited by many challenges, such as inadequate space, low staffing and a large clientele, leading to burn-out at the workplace.

Pearson's chi-squared test was performed to determine the relationship between a poor work environment and years of work experience as a midwife. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The p-value was 0.000, which indicated a statistically significant association between these two variables. Thus, the result indicated that midwives could be affected by a poor work environment depending on the number of years of their experience.

#### 4.4.3.7 *Language barrier between the midwife and the woman*

Respondents were asked to indicate whether a language barrier is an inhibiting factor in their caring behaviour during childbirth. Figure 4.35 below indicates the responses.



**Figure 4.35: Language barrier between the midwife and the woman**

Figure 4.35 above shows that a few respondents 48% (n=96) reported that a language barrier between midwives and women was not an inhibiting factor affecting the caring behaviour of midwives during childbirth. Of this number, 36.5% (n=73) disagreed with the statement. Therefore, the results showed that the midwives in the study did not think that a language barrier was a problem when they cared for women in labour.

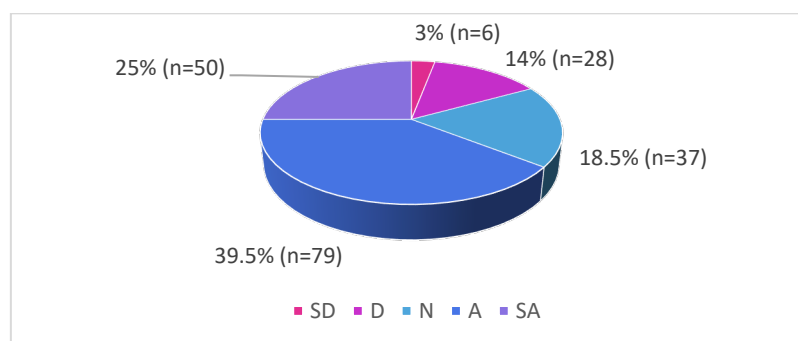
Khresheh and Barclay (2019:72), Lambert *et al.* (2018:260) and Munabi-Babigumira *et al.* (2017:17) explain that the use of positive encouraging words the meaning of which is indicated by the tone of voice used by a health worker. Therefore, midwives ought to use words and a tone of voice that does not encourage communication, trust and autonomy when providing care during childbirth.

Bohren *et al.* (2019:7), however, maintain that labouring women are often dissatisfied with midwives' explanations because they do not understand them, particularly in the case of migrant women because of the language barrier. Moreover, as communication between midwife and woman is vital during childbirth, a language barrier could be a problem, as indicated by the respondents who viewed it as a factor inhibiting caring behaviour.

Pearson's chi-squared test determined the relationship between a language barrier and years of work experience. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The result was a p-value of 0.557, which indicated that there was no significant statistical association, and the number of years of experience of a midwife would make no difference to how they experience a language barrier.

#### 4.4.3.8 *Lack of verbal appreciation from supervisors*

Respondents were asked to indicate whether a lack of verbal appreciation from supervisors is a factor hindering caring behaviour during childbirth. Figure 4.36 below indicates whether a lack of verbal appreciation from supervisors was identified by the respondents as an inhibiting factor in midwives' caring behaviour.



**Figure 4.36: A lack of verbal appreciation from supervisors**

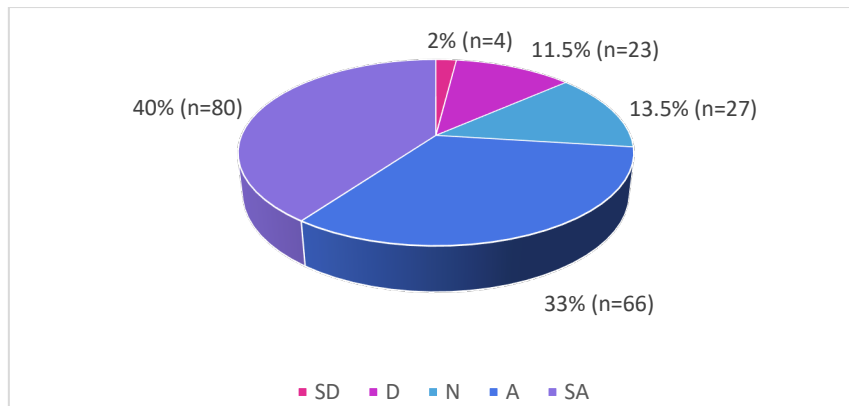
Figure 4.36 above shows that many respondents 64.5% (n=129) agreed that a lack of verbal appreciation from supervisors of the work that had done was a factor inhibiting the caring behaviour of midwives, and of that number, 25% (n=50) strongly agreed with the statement. These results showed that midwives were mindful that a lack of work appreciation, acknowledgement and support from the supervisors negatively affected their caring behaviour.

Studies conducted by Mestdagh *et al.* (2019:6) and Ndwiga *et al.* (2017:6) found that the caring behaviour of midwives is stimulated and anchored by supportive management. Therefore, supervisors play a major role in building staff morale and as revealed in the current study, caring behaviour is marred as is their autonomy and emotional well-being if midwives feel they are not appreciated, valued or supported by supervisors. However, as the study only investigated verbal support, other forms of support could be investigated in future studies.

Pearson's chi-squared test determined the relationship between a lack of verbal appreciation by supervisors and years of work experience as a midwife. Polit and Beck (2018:245); Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The p-value was 0.000, which indicated a statistically significant association, which indicated that depending on their work experience midwives might be affected by a lack of verbal appreciation by the supervisors to anchor their morale.

#### 4.4.3.9 *Inconsistent selection of staff for professional development*

Respondents were asked to indicate whether the inconsistent selection of staff for professional development is a factor inhibiting the caring behaviour of midwives. Figure 4.37 below indicates the responses.



**Figure 4.37: Inconsistent selection of staff for professional development**

Figure 4.37 above shows that most of the respondents 73% (n=146) agreed that the inconsistent selection of staff for professional development inhibits caring behaviour, while of that number, 40% (n=80) strongly agreed with the statement. Therefore, the study results showed that the midwives in the study agreed that the inconsistent selection of staff for professional development inhibits their caring behaviour during childbirth.

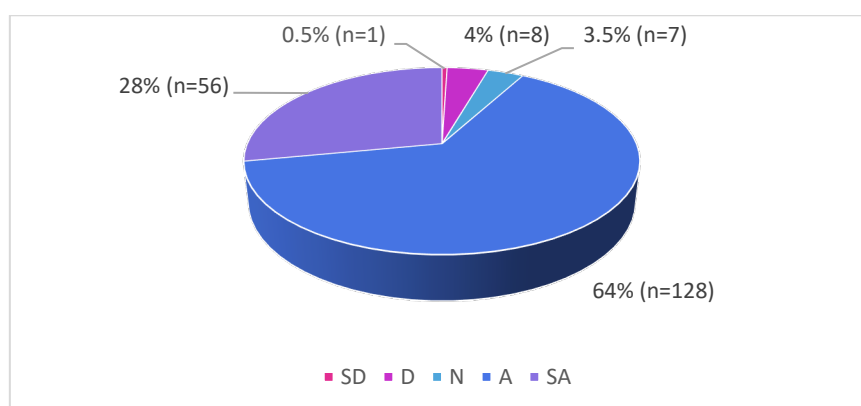
This complies with the results of the studies conducted by Weldearegay *et al.* (2020:9); Mestdagh *et al.* (2019:5); McMahon *et al.* (2018:2) and Munabi-Babigumira *et al.* (2017:5), which that health workers' competencies were limited by inadequate in-service education and selection for professional development. Moreover, innovative caring behaviour is seen in people with advanced skills and knowledge, which indicates that a lack of staff development leads to poor job performance.

Pearson's chi-squared test was to investigate the relationship between the inconsistent selection of staff for professional development and years of experience as a midwife. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The p-value was 0.000, thereby indicating a statistically significant association which suggests that midwives might be affected by a lack of staff development depending on the number of years of their work experience.



#### 4.4.3.10 Lack of equipment

Respondents were asked to indicate whether a lack of equipment was a factor inhibiting the caring behaviour of midwives. Figure 4.38 below indicates their responses.



**Figure 4.38: A lack of equipment**

Figure 4.38 above shows that most of the respondents 92% (n=184) agreed that a lack of equipment at the workplace inhibited caring behaviour during childbirth, and of that number, 28% (n=56) strongly agreed with the statement. These results showed that midwives in the study were aware that their caring behaviour was affected by a lack of equipment and led to a failure to meet professional standards of care.

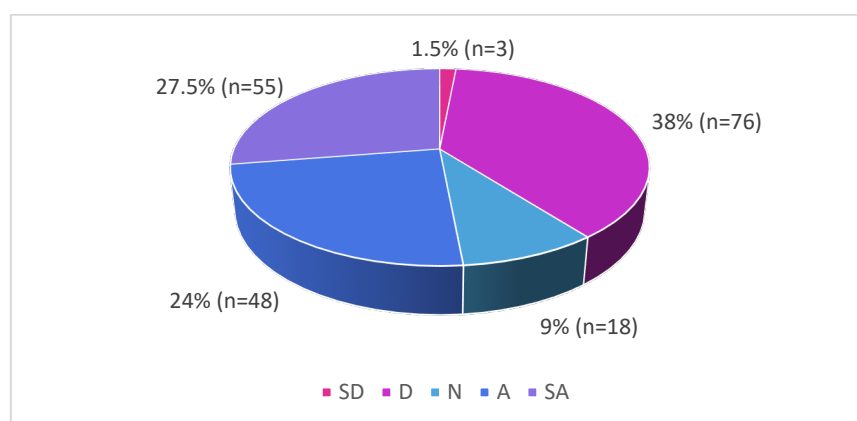
These results were consistent with those of the studies conducted by Bohren *et al.* (2019:8) and Munabi-Babigumira *et al.* (2018:12), which found that inadequate medical supplies, such as medication and medical/non-medical commodities, caused unnecessary stress in the midwifery work environment. In addition, a lack of equipment limits midwives' ability to deliver appropriate care to women during childbirth, affects the patient's right to the highest attainable level of care during delivery and leads to low morale and emotional stress in carers.

Pearson's chi-squared test investigated the relationship between a lack of equipment and years of experience as a midwife. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The p-value was 0.150, which indicated that there was no statistically significant relationship between these two

variables, thereby suggesting that the number of years of their experience would not have any impact on how midwives experience a lack of equipment.

#### 4.4.3.11 Lack of transport

Respondents were asked to indicate whether a lack of transport was a factor inhibiting the caring behaviour of midwives when nursing women during childbirth. Figure 4.39 below indicates whether a lack of transport was identified as an inhibiting factor.



**Figure 4.39: A lack of transport**

Figure 4.39 above shows that most of the respondents 51% (n=103) agreed that a lack of transport was an inhibiting factor affecting the caring behaviour of midwives during childbirth, while 27.5% (n=55) strongly agreed that it was a deterrent. However, 39.5% (n=79) disagreed that a lack of transport was an inhibiting factor, while of that number, 38% (n=76) strongly disagreed with the statement.

These results suggested that although most midwives' agreed that a lack of transport was a barrier to caring behaviour, quite a few disagreed. This discrepancy might have been due to work location. For instance, for midwives working in hospital maternity units, a lack of transport might not have been a problem, unlike those working in the clinics with maternity units who had to share transport with other clinics in their catchment areas (MoHW, 2011b). These results confirm those of the studies conducted by Bradley *et al.* (2019:2) and Bohren *et al.* (2019:8), which revealed that the availability of resources such as transport influences the delivery of quality maternal health care to women.

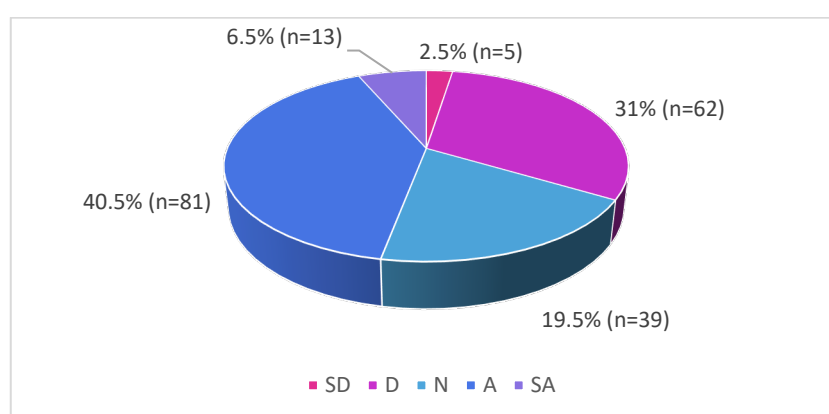
A lack of transport also means that midwives cannot transport women at a convenient time to or from facilities for continuity of care and to avoid delay. Malatji and Madiba

(2020:10) and Munabi-Babigumira *et al.* (2018:12) indicate that a lack of transport limits midwives' ability to deliver appropriate care. For instance, when a woman needs to be referred to another facility, the failure to arrange suitable transportation is a barrier which leads to a delay in obtaining accessible, equitable and quality maternal health care, which interferes with the caring behaviour of midwives.

Pearson's chi-squared test was performed to determine the relationship between a lack of transport and years of work experience as a midwife. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The p-value was 0.064, which indicated that there was no statistically significant association, thereby suggesting that the number of years of their experience would not have any impact on how midwives experience a lack of transport.

#### 4.4.3.12 *Inconsistent following of protocol*

Respondents were asked to indicate whether the inconsistent following of protocol/official procedures in the form of guidelines, standards and procedures for maternal health care was a factor inhibiting their caring behaviour during childbirth. Figure 4.40 below indicates their response.



**Figure 4.40: Inconsistent following of protocol**

Figure 4.40 above shows that some respondents 47% (n=94) indicated that the inconsistent following of protocol (inhibits the caring behaviour of midwives, and of that number, 40.5% (n=81) agreed with the statement. However, several respondents 19.5% (39) were neutral about the statement. These results suggest mixed opinions,

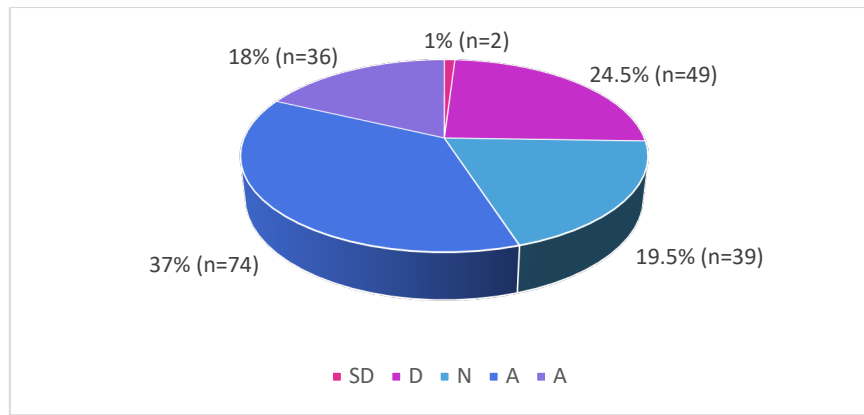
although the results that suggested that caring behaviour is negatively affected by the inconsistent following of protocol were in line with the results of Bohren *et al.*'s (2019:8), Lambert *et al.*'s (2018:260) and Munabi-Babigumira *et al.*'s (2018:10) studies which revealed that midwives' failure to adhere to meet professional standards of care meant that the basic needs of women during childbirth were not met. Examples are the inconsistent use of partograph and the failure to obtain informed consent and ensure confidentiality when caring for conducting physical examinations and episiotomies (Bowser & Hill, 2010:3-5).

Midwives believed that sometimes they were caught up in providing care and did not communicate with a woman about every procedure or examination because they had repeated them so often. However, the midwives in the study were mindful that this kind of behaviour had an impact on a woman's childbirth experience and was a violation of their right to respectful, dignified and humane care during childbirth.

Pearson's chi-squared test was performed to fathom the relationship between the inconsistent use of protocol and the years of experience as a midwife. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The p-value was 0.090, which indicated a statistically insignificant association between these two variables, thereby suggesting that the inconsistent use of protocol would affect midwives, depending on the number of years of their work experience.

#### *4.4.3.13 Demanding attitude of a woman*

Respondents were asked to indicate whether the demanding attitude of a woman is a factor inhibiting caring behaviour. Figure 4.41 below indicates whether the demanding attitude of the woman was identified as an inhibiting factor by the respondents.



**Figure 4.41: Demanding attitude of the woman**

Figure 4.41 above shows that most of the respondents 55% (n=110) reported that the demanding attitude of the woman inhibits the caring behaviour of midwives, and of that number, 37% (n=74) agreed with the statement. However, 19.5% (n=39) were neutral about the statement, which leaves room for future research studies. The results justify that the midwives in the study mostly considered the demanding attitude of a woman in labour as an inhibiting factor affecting their caring behaviour.

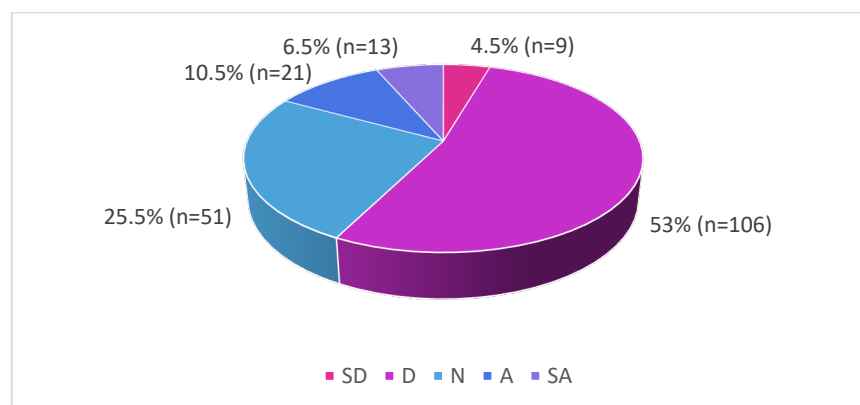
The studies conducted by Bohren *et al.* (2019:5), Lambert *et al.* (2018:259-260) and Lohmann *et al.* (2018:55) showed that midwives' work overload due to a shortage of staff makes caring behaviour difficult and therefore the demands of a labouring woman might further limit it. For example, some women tend to push before being instructed to do so and refuse to push as instructed by midwives. Therefore, this kind of disobedience forces midwives to deal with their anger or frustration due to a noncompliant woman, which leads to confrontational interactions between the woman and the midwife. The literature corroborates with the study's result because even though women have the right to the highest attainable standard of care during childbirth, sometimes woman's demands are overwhelming to the extent that they impact the caring behaviour of midwives.

As Peprah *et al.* (2018:67) indicate, however, knowing and evaluating the attitude and perceptions of the woman might pre-empt a demanding attitude and prevent her demands from becoming an inhibiting factor affecting the midwife's caring behaviour. Moreover, this is necessary not only to protect the woman's fundamental rights and autonomy but also to promote a safe and positive childbirth experience.

Pearson's chi-squared test was performed to investigate whether there was a statistically significant relationship between the demanding attitude of women and years of work experience as a midwife variable. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The result was a p-value of 0.266, which indicated an insignificant statistical association, thereby suggesting that the number of years of their experience would not have any impact on how midwives experience a labouring woman's demanding attitude.

#### 4.4.3.14 Woman with no education

Respondents were asked to indicate whether a labouring woman with no academic education is a factor inhibiting caring behaviour. Figure 4.42 below indicates the responses.



**Figure 4.42: Woman with no education**

Figure 4.42 above reveals that just over half of the respondents 57% (n=115) disagreed that dealing with a labouring woman with no education is an inhibiting factor affecting the caring behaviour of midwives. However, 53% (n=106) thought that it is, and 25.5% (n=51) were neutral. Thus, responses were mixed, which leaves room for future research.

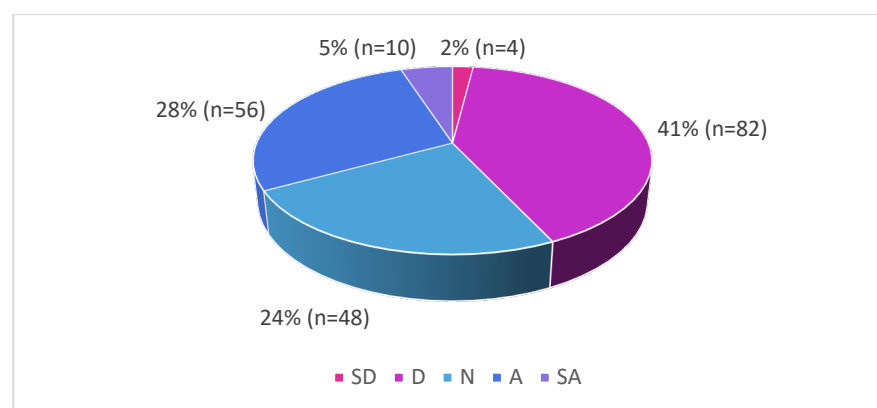
A study conducted by Bohren *et al.* (2019:11) found that a third of women with little education are stigmatised and experience discrimination and mistreatment during childbirth. Bohren *et al.* (2019:11) found that women with no education 95.0% (n=2016) and younger women were more likely to experience uncaring behaviour such as verbal

abuse compared with older women (>30 years and above). This was incongruent with the study's mixed results, which suggested that some of the midwives in the study showed caring behaviour irrespective of the labouring women's educational status.

Pearson's chi-squared test was performed to investigate whether years of experience affected how midwives treated women with no education. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The p-value was 0.529, which indicated no statistically significant association between the variables, thereby suggesting that the number of years of their experience would not have any impact on how midwives experience a labouring woman with no education.

#### 4.4.3.15 *Women with some education*

Respondents were asked to indicate whether women with some education was a factor inhibiting the caring behaviour of midwives. Figure 4.43 below indicates their responses.



**Figure 4.43: Women with some education**

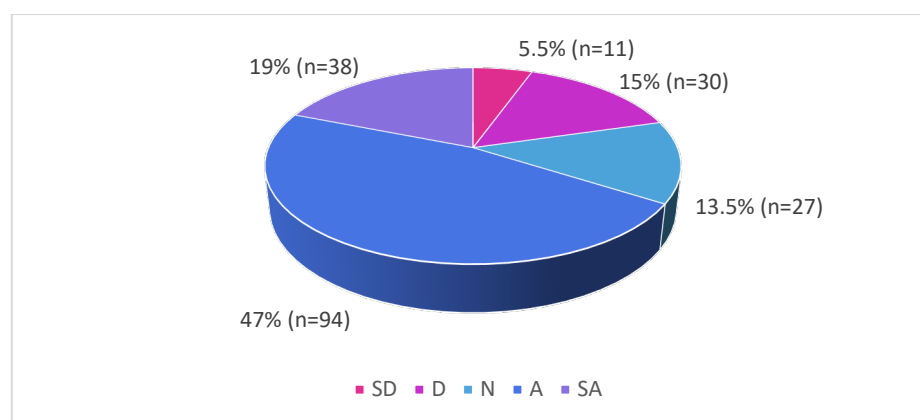
Figure 4.43 above shows that some respondents 43% (n=86) indicated that women disagreed that some education was an inhibiting factor affecting the caring behaviour of midwives, and of the number, 41% (n=82) agreed that it was. However, a fair number 24% (n=48) were neutral. These mixed results leave room for future research. Nevertheless, some midwives were aware that there could be a problem in tending to a labouring woman with some education, thereby affecting the functional embedding of available, accessible, acceptable, respectful and women-centred maternal care

within the healthcare system (Lohmann *et al.*, 2018:53; Lambert *et al.* 2018:257), needs to be. Moreover, Mårtensson *et al.* (2020:1128) opine that caring behaviour puts the needs of the woman first and respects her dignity regardless of her education.

Pearson's chi-squared test was performed to determine whether there was a relationship between the variable of a woman with some education and years of work experience as a midwife. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The p-value was 0.049 indicating a statistically significant association between the two variables, thereby suggesting that women with some education would affect midwives, depending on the number of years of their work experience.

#### 4.4.3.16 Young age of the woman (<15 years)

Respondents were asked to indicate whether the young age (<15 years) of a labouring woman as a factor inhibiting caring behaviour. Figure 4.44 shows the responses.



**Figure 4.44: Young age of the woman (<15 years)**

Figure 4.44 above shows that most of the respondents 66% (n=132) agreed that the young age of a woman in labour is a factor inhibiting caring behaviour, and of this number, 19% (n=38) disagreed with the statement, whilst 5.5% strongly disagreed. These results show that the midwives in the study were aware that the young age of a woman in labour inhibited their caring behaviour, which concurs with the literature.

Bohren *et al.*'s (2019:8) study found that young women aged between 15 and 19 years and less educated women were at the highest risk of uncaring treatment in facility-

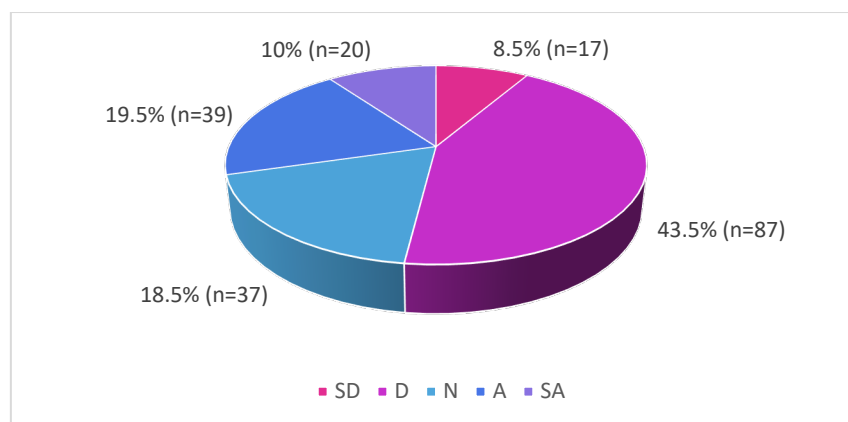


based childbirth, such as verbal and physical abuse. The reason for this could be that women in this age group are still teenagers, they have never been exposed to the birthing process, do not listen to instructions and have insufficient knowledge, which makes them uncooperative (Mayra *et al.* (2021:5).

Pearson's chi-squared test was investigated between the younger age of the woman (<15 years) and years of work experience as a midwife. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The p-value was 0.512, which indicates no statistically significant association, thereby suggesting that the number of years of a midwife's experience would not have any impact on how she/he experiences a young labouring woman.

#### 4.4.3.17 Older age of the woman (30 years and above)

Respondents were asked to indicate whether advanced maternal age (>30 years) had an impact on midwives' caring behaviour. Figure 4.45 below indicates the responses.



**Figure 4.45: Older age of the woman (30 or more years)**

Figure 4.45 above shows that most of the respondents 52% (n=104) disagreed that older women could be a factor inhibiting midwives' caring behaviour, and 43.5% (n=87) agreed. These results show that only some of the midwives in the study were aware that women of advanced maternal age had an impact on their caring behaviour, which concurs with the literature.

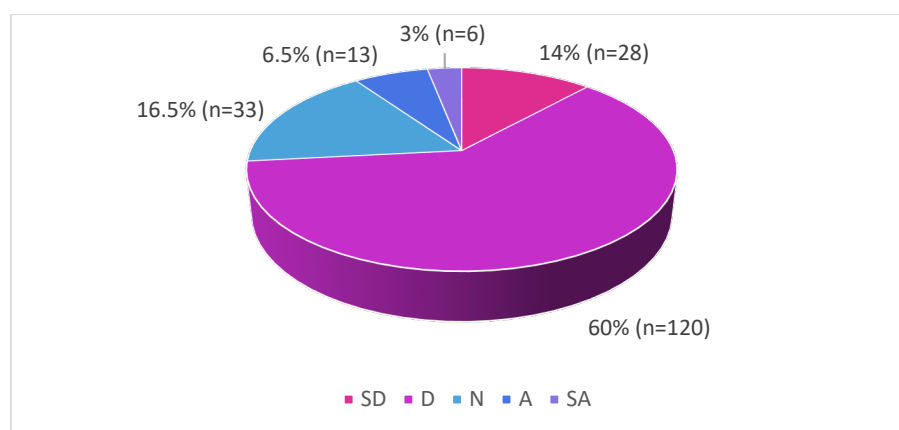
The studies conducted by Mayra *et al.* (2021:5) and Bohren *et al.* (2019:11) revealed that a woman's age (>30 years and above) and parity are more likely to experience

uncaring during childbirth. The above-mentioned authors indicated that older women hear judgmental comments for having too many children or having them too late. Yet, the results of the study mostly suggested that older women are less likely to experience uncaring behaviour during childbirth because it might be that they have been exposed to and have knowledge about and expectations for maternal care. The results of the current study were partially not congruent with the literature on older women in labour.

Pearson's chi-squared test investigated the relationship between the older age of the woman (>30 years) and years of work experience as a midwife. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The p-value was 0.006, which indicates a statistically significant association, thereby suggesting that the number of years of a midwife's experience would have an impact on how she/he experienced an older labouring woman.

#### 4.4.3.18 *Marital status of the woman (single)*

Respondents were asked to indicate whether a single woman would be a factor inhibiting the caring behaviour of midwives. Figure 4.46 below indicates the responses.



**Figure 4.46: Marital status of the woman (single)**

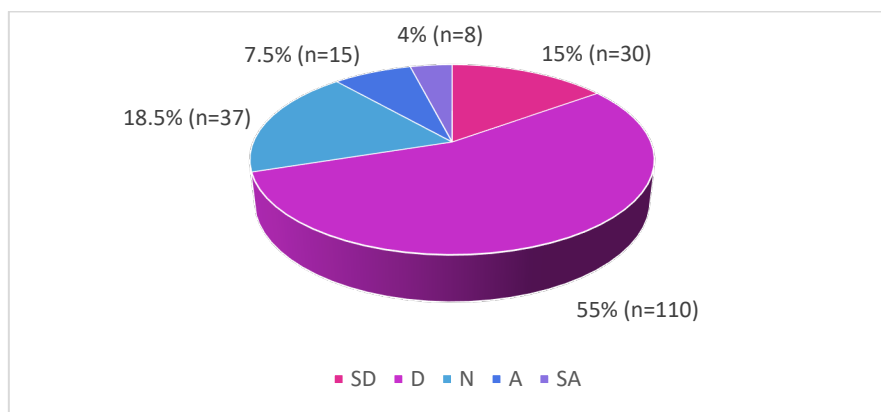
Figure 4.46 above shows that most of the respondents 74% (n=148) disagreed that single women are a factor inhibiting the caring behaviour of midwives, and of this number, 14% (n=28) strongly disagreed with the statement. This contradicts the literature because Bohren *et al.* (2019:9-11) maintain that unmarried younger women

are likely to be targets of uncaring behaviour, such as undergoing procedures without having given consent. Thus, the midwives in the study were mostly aware that they should provide labouring women with care that makes them feel safe and comfortable regardless of their marital status.

Pearson's chi-squared test was performed to investigate whether there was a relationship between the marital status of the woman and years of work experience as a midwife. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The result was a p-value of 0.599, which indicated no statistically significant association between the two variables, thereby suggesting that the number of years of a midwife's experience would have no impact on how she/he reacts to a single labouring woman.

#### 4.4.3.19 *Marital status of the woman (married, cohabiting)*

Respondents were asked to indicate whether a married or cohabiting woman in labour is a factor inhibiting the caring behaviour of midwives. Figure 4.47 below indicates their responses.



**Figure 4.47: Marital status of the woman (married, cohabiting)**

Figure 4.47 above shows that many respondents 70% (n=140) disagreed and strongly disagreed that a woman who was married or cohabiting with a partner is a factor inhibiting the caring behaviour of midwives. Moreover, a mere 11.5% (n=232) agreed/strongly agreed, and 18.5% (n=37) of respondents were neutral. Therefore, the results showed that most of the midwives in the study were aware that women in

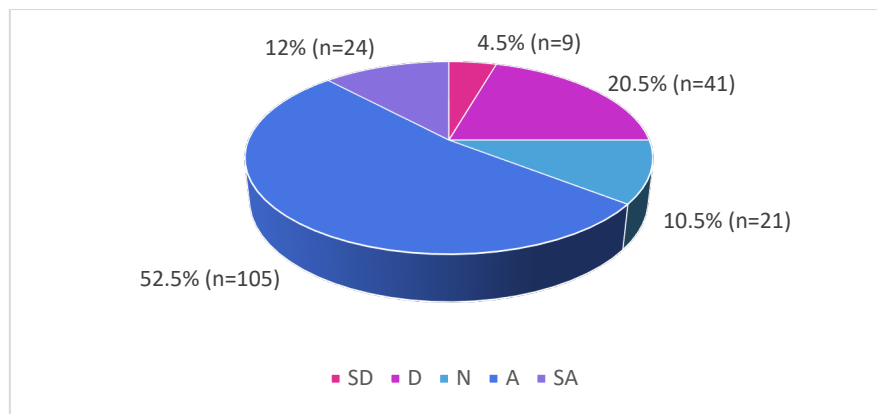
labour who are married or cohabiting is a factors inhibiting caring behaviour. However, this contradicts the literature

Mobbs, Williams and Weeks (2018:2) maintain that intrapartum care must keep in pace or align with societal norms and expectations and that as a woman's social choices are no concern of the midwives caring for them, they should focus on giving respectful and dignified maternal health care, instead of worrying about their marital status. Moreover, the studies conducted by Malatji and Madiba (2020:6) and Bohren *et al.* (2019:9-11) revealed that midwives were judgemental when caring for women during childbirth and thus made negative comments about their parity, marital status and whether they were married or cohabiting instead of concentrating on their right to the highest attainable standard of care during childbirth and to be free from discrimination (WHO, 2018:195-200).

Pearson's chi-squared test was performed to determine the relationship between the marital status of the woman (married or cohabiting) and years of work experience as a midwife. Polit and Beck (2018:245); Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The p-value was 0.709, which indicated a statistically insignificant association between the variables, thereby suggesting that the number of years of a midwife's experience would have no impact on how she/he reacts to a married/cohabiting woman in labour.

#### *4.4.3.20 Parity of the woman (first childbirth)*

The parity of a woman refers to the number of children born alive. Respondents were asked to indicate whether a woman giving birth for the first time is a factor inhibiting the caring behaviour of midwives. Figure 4.48 below indicates their responses.



**Figure 4.48: Parity of the woman (first childbirth)**

Figure 4.48 above shows that many respondents 64.5% (n=129) agreed that woman who gave birth for the first time was a factor inhibiting the caring behaviour of midwives, and of this number, 12% (n=24) strongly agreed. These results show that the midwives in the study were aware that parity is an inhibiting factor affecting their caring behaviour, which should be addressed because as the WHO (2018:198-200) maintains, every woman has the right to the highest attainable standard of care during childbirth. Moreover, the results concur with the literature. For example, John *et al.* (2020:166) point out that a woman's experience of the birth of her first child and her first encounter with the baby will remain in her memory, be described in detail many years later and influence her future childbirth choices.

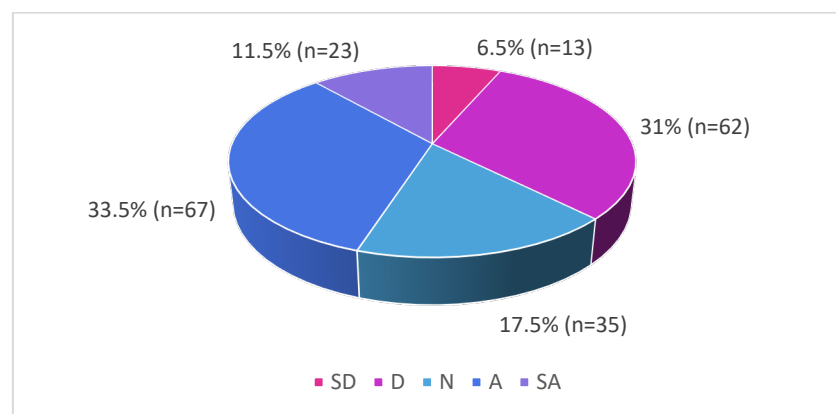
The studies of Al-Maharma (2021:2); Bradley *et al.* (2019:5) and Bohren, *et al.* (2019:11) found that several women reported their first childbirth experiences as uncaring. In addition, Khresheh *et al.* (2019:4) and John *et al.* (2020:166, 167) maintain that verbal and physical abuse is a common form of uncaring experienced by women giving birth for the first time. Midwives shout at them and speak to them harshly when the women fail to understand what is expected of them, instead of understanding that this is their first experience of the childbirth process. These uncaring experiences leave the women feeling humiliated, whereas the midwives should focus on preserving the dignity of the women and making the women feel that they are in the safe hands of a caring midwife.

Pearson's chi-squared test determined the relationship between the parity of the woman (first childbirth) and years of work experience as a midwife. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value

calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The p-value was 0.094, which indicated no statistically significant association, thereby suggesting that the number of years of a midwife's experience would have no impact on how she/he reacts to the parity (first birth) of a woman in labour.

#### 4.4.3.21 Parity of the woman (more than one childbirth)

Respondents were asked to indicate whether a woman who has given birth more than once is a factor inhibiting the caring behaviour of midwives. Figure 4.49 below indicates their responses.



**Figure 4.49: Parity of the woman (more than one childbirth)**

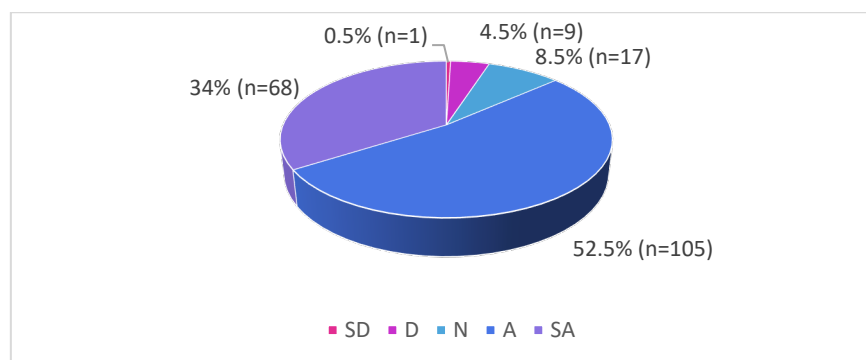
Figure 4.49 above shows that just under half of the respondents 45% (n=90) agreed that the parity of the woman (more than one child) is an inhibiting factor affecting the caring behaviour of midwives. In addition, of this number, 11.5% (n=23) strongly agreed. However, 17.5% (n=35) were neutral about the statement, and 37% disagreed of which 11.5% (n=23) strongly disagreed. These results showed mixed results, which leaves room for future research. However, the results revealing agreement with the statement concurred with the literature. For example, the studies conducted by Al-Maharma (2021:2), Malatji and Madiba (2029:6) and Bohren, *et al.* (2019:6-8,11) reported that even women who had given facility-based childbirth before experienced uncaring behaviour, such as verbal and physical abuse were a common form of uncaring experienced by women during childbirth. Moreover, women reported that midwives humiliated them, shouted at and spoke to them harshly and were judgemental about their parity, age and lack of cooperation. This suggests that

midwives expected women with more than one child to be experienced in giving birth, which led to them being impatient and uncaring instead of providing the support to which they were entitled.

Pearson's chi-squared test determined the relationship between the parity of the woman (more than one childbirth) and years of work experience as a midwife. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The p-value was 0.026, which indicated that there was a statistically significant association, thereby suggesting that the number of years of a midwife's experience would have an impact on how she/he reacts to the parity (more than one childbirth) of a woman in labour.

#### 4.4.3.22 *Negative attitude of the woman*

The respondents were asked to indicate whether the negative attitude of the woman in labour childbirth is a factor inhibiting the caring behaviour of midwives. Figure 4.50 below indicates their responses



**Figure 4.50: Negative attitude of the woman**

Figure 4.50 above shows that by far, most of the respondents 87.5% (n=173) agreed that the negative attitude of the woman inhibits a midwife's caring behaviour, and of this number, 34% (n=68) strongly agreed with the statement. The results concurred with the literature. For example, Rominski *et al.* (2017:219) note that often women refuse to follow midwives' instructions as to when to push, be sutured after an episiotomy and cooperate, which could lead to the midwife behaving uncaringly. However, Al-Maharma *et al.* (2021:2); Mårtensson *et al.* (2020:1124) and Khresheh

and Barclay (2019:73) maintain that care during childbirth should involve the midwife being available to the woman, thereby continually providing emotional, physical and spiritual support. However, this is difficult and there might be distrust, if the woman has a negative attitude, even if the midwife is aware of the need for effective communication and caring behaviour (Lambert *et al.*, 2018:259).

Pearson's chi-square test was performed to investigate whether there was a relationship between the negative attitude of the woman and the years of work as a midwife. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value calculated by the test is less than 0.05, there is a statistically significant association, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. The p-value was 0.102, which indicated no statistically significant association, thereby suggesting that the number of years of a midwife's experience would not have an impact on how she/he reacts to the negative attitude of a woman in labour.

#### **4.4.3.23      *Categorisation of factors***

As indicated in the sections above, the results showed that more than half of the respondents reported the following as inhibiting factors: a shortage of staff 53.0%, (n=107); work overload 51.5% (n=103); a poor work environment 62.0% (n=125); a lack of equipment 64.0% (n=128); the parity of the woman (first childbirth) 52.0%, (n=105); the young age of the labouring woman (<15 years); and the negative attitude of the woman 52.0% (n=105). These inhibiting factors were categorised into health-system-related (a lack of equipment, a poor work environment); woman-related (the parity of the woman/first childbirth, the negative attitude of the woman; the young age of the labouring woman); and midwife-related (a shortage of staff, work overload).

#### **4.4.4      *Relationship between midwives' years of experience and their caring behaviour***

Pearson's chi-squared tests were performed to investigate the relationship between the years of experience of the midwives in the study and the caring behaviour they identified. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value test is less than 0.05, there is a statistically significant relationship between the variables, and a p-value greater than 0.05 indicates that there is a



statistically insignificant association. Table 4.2 below provides the results of the tests, although only statistically significant relationships are reported.

**Table 4.2: Midwives' years of experience/caring behaviour**

Variables code	Description of variable	Chi-squared test (p-value)*
B3	Exploring the woman's needs	.036**
B9	Putting the needs of the woman first	.015
B15	Sharing responsibility with the woman	.000
B16	Keeping relatives informed about the woman	.017
B17	Showing genuine interest	.002
B18	Staying on duty to complete work after the shift ended	.020

Note: \*p-value obtained by Pearson's chi-squared test

\*\* p-value  $\leq 0.05$ ) is statistically significant

Examples of variable codes: A4=Section A: Variable 4; B3=Section B: Variable 3

Table 4.2 above shows that of all the 21 caring behaviour variables, only 6 had a statistically significant association with midwives' years of work experience because the p-value test was less than 0.05.

#### ***4.4.5 Relationship between the midwives' years of experience and factors inhibiting caring behaviour***

Pearson's chi-squared tests were performed to investigate the relationship between the years of experience of the midwives in the study and the factors inhibiting the caring behaviour they identified. Polit and Beck (2018:245), Fain (2017:284) and Maree (2016:229) maintain that when a p-value test is less than 0.05, there is a statistically significant relationship between the variables, and a p-value greater than 0.05 indicates that there is a statistically insignificant association. Table 4.3 below provides the results of the tests, although only statistically significant relationships are reported.

**Table 4.3: Midwives' years of work experience/inhibiting factors**

Variable code	Description of variable	Chi-squared test (p-value)*
C1	Shortage of staff	.000**
C2	Work overload	.000
C4	Absenteeism	.001
C5	Poor collaboration with colleagues	.000
C6	Poor working environment	.000
C8	Lack of verbal appreciation from the supervisors	.000
C9	Inconsistent selection of staff for professional development	.000
C17	Older age of the woman (30 or more years)	.006
C21	Parity of the woman (more than one childbirth)	.026

Note: \*p-value obtained by Pearson's chi-squared test

\*\* p-value  $\leq 0.05$ ) is statistically significant

Examples of variable codes: A4=Section A: Variable 4; B3=Section B: Variable 3

Table 4.3 above shows that of the 22 inhibiting factor variables, only 9 had a statistically significant association with midwives' years of work experience because the p-value test was less than 0.05.

#### **4.5 Summary of the chapter**

This chapter presented, interpreted and discussed the results of the analysis of the data captured through the self-administered questionnaire. The respondents identified caring behaviour and the factors inhibiting the caring behaviour of midwives indicated in the statements of the questionnaire. Frequency tables and pie charts were utilised to present the results for an easy understanding of the phenomenon studied. During the discussions, the results, where relevant, were linked to the literature. The following chapter explains the development and presentation of recommendations for midwives and unit managers to optimise the caring behaviour of midwives when nursing women during childbirth in Botswana.

## CHAPTER 5

### RECOMMENDATIONS TO MIDWIVES AND UNIT MANAGERS FOR THE OPTIMISATION OF CARING BEHAVIOUR IN MIDWIVES IN BOTSWANA

#### 5.1 Introduction

The previous chapter presented, interpreted and discussed the analysed data, which guided the researcher in the design and development of recommendations to midwives and unit managers for the optimisation of caring behaviour in midwives in Botswana. The results of the data analysis achieved the first two objectives of the study, which were to do the following:

- Identify the caring behaviours of midwives who nurse women in Botswana
- Determine the factors that inhibit caring behaviour in midwives in Botswana

This chapter achieves the third research objective, which was to do as follows:

- Make recommendations for midwives and unit managers that could be used to optimise the caring behaviour of midwives when nursing women during childbirth in Botswana.

#### 5.2 Summary of results

This section summarises the key results of the analysis of the data gathered from the respondents' responses to the questions in the three sections of the questionnaire (see Annexure H). Section A of the questionnaire gathered demographic data, Section B collected data on the caring behaviour of midwives and Section C collected data on the factors inhibiting the caring behaviour of midwives.

##### 5.2.1 Section A: Demographic data

Most of the respondents 40.5% (n=81) were aged between 40 and 49 years, 92% (n=184) were female, and 97% (n=194) held a diploma in nursing and midwifery. In addition, 31% (n=62) had 6 to 10 years of work experience as a midwife, 36.5% (n=73) had worked 5 and more years in the unit, half of the respondents 58% (n=116) were working in clinics with maternity units, and 94% (n=188) indicated that they were satisfied working as midwives.

### **5.2.2 Section B: Midwives' caring behaviour**

The results of the data analysis revealed that most of the respondents gave positive responses to 17 statements (B1 to B11, B13, B15, B17, B19, B20 and B21), which led to the identification of their caring behaviour and suggested that the respondents' behaviour was mostly caring.

Responses to four of the statements (B12, B14, B16, and B18) indicated that the respondents did not demonstrate the following caring behaviour: arranging for the labouring patient to see her relatives; respecting her preferences; keeping her relatives informed; and staying on duty to complete work after the shift had ended, which suggests that the midwives in the study did not completely meet the professional standards of midwifery practice.

### **5.2.3 Section C: Factors that inhibiting the caring behaviour of midwives**

The results of the data analysis revealed that more than half of the respondents maintained that items C1, C2, C6, C10, C16, C20 and C22 were inhibiting factors. These factors were as follows: a shortage of staff; a heavy workload; an inadequate working environment; a lack of equipment; the young age of the labouring woman (<15 years); the parity (first child); and the negative behaviour of the woman in labour.

## **5.3 Recommended caring behaviours for midwives and unit managers**

The behaviour of midwives affects how women participate in and experience childbirth. Moreover, if a midwife is uncaring, a woman may experience emotional harm during childbirth or be reluctant to seek care and report to a maternity unit when in labour (Malatji & Madiba, 2020:7; Mårtensson *et al.*, 2022:1123). However, when women are seen, heard and trusted by midwives, they are more likely to follow their instructions. Therefore, as the research results revealed that the respondents were not completely caring, recommendations are made in this section for midwives and unit managers that could be used to optimise caring behaviour. These recommendations are based on Swanson's (1991) Theory of Caring, which involves caring behaviours termed "knowing"; "being with"; "doing for"; "enabling" and "maintaining belief" (Swanson, 1991, 1993, 1991a, 1991b, 1999c).

### 5.3.1 Design of the recommendations

As stated above, the recommendations follow Swanson's (1991) framework of caring processes and will be explained according to the headings indicated in Table 5.1 below:

**Table 5.1: Design of the recommendations**

Caring Behaviour	Description
Caring Behaviour 1	Knowing
Caring Behaviour 2	Being with
Caring Behaviour 3	Doing for
Caring Behaviour 4	Enabling
Caring Behaviour 5	Maintaining belief

### 5.3.2 Development of the recommendations

The recommendations were developed to be used as an instrument for the optimisation of caring behaviour in midwives. Mårtensson *et al.* (2022:1123) conducted a study to develop and test caring behaviour using a coding scheme based on Swanson's (1991) Theory of Caring. Mårtensson *et al.*'s (2022:1123) study inspired the researcher to develop her recommendations to midwives and unit managers based on Swanson's (1991) Theory of Caring. In addition, the researcher's recommendations were developed according to the criteria presented in Table 5.2 below:

**Table 5.2: Criteria for developing recommendations**

<u>Recommendations should be as follows:</u> <ul style="list-style-type: none"><li>• Clear and easy to define</li><li>• In line with the mission and values of the Ministry of Health and Wellness of Botswana</li><li>• Applicable to a midwifery clinical setting</li><li>• Incorporated into other nursing initiatives</li></ul>
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### **5.3.3 Target group for recommendations**

The recommendations are targeted at midwives and unit managers. The researcher acknowledges that they might also be meaningful to other stakeholders.

### **5.3.4 Recommended caring behaviours for midwives and unit managers**

The recommendations below are based on Swanson's (1991) five caring processes listed in Table 5.1 above, which will be operationalised according to the format that is presented in Table 5.3 below.

**Table 5.3: Operationalising recommended caring behaviour**

- |  |
|--|
| <ul style="list-style-type: none"><li>• Operational definition of the caring behaviour</li><li>• Operational indicators of the caring behaviour</li><li>• Criteria for the caring behaviour in midwives</li><li>• Criteria for the caring behaviour in unit managers</li></ul> |
|--|

### **5.3.5 Caring Behaviour 1: Knowing**

#### **5.3.5.1 Operational definition of knowing**

Knowing is striving to understand an event according to its meaning in the life of another (Mårtensson *et al.*, 2022:1125; Kalfoss & Owe, 2015:979; Swanson, 1991:163; 1993). Therefore, in the context of midwifery, knowing involves avoiding making assumptions about the meaning of an event. Midwives would rather try to know the labouring woman's needs and know how to respond appropriately to satisfy them. To achieve this, midwives need to create a calm and welcoming atmosphere to help their patients feel comfortable and free to express their needs.

#### **5.3.5.2 Operational indicators of knowing**

The operational indicators of knowing are the midwives' actions that demonstrate their knowledge of the woman's needs during childbirth, such as performing patient-centred tasks that lead to their satisfaction, thereby indicating humanity, respect, kindness insight, sensitivity and empathy (Kalfoss & Owe, 2015:979).

#### 5.3.5.3 Criteria for knowing (midwives)

##### Background

The results of the data analysis revealed that half of the respondents felt that the following factors prevented them from knowing their patients: understaffing 53.5% (n=107); and work overload 51.5% (n=103). Furthermore, these factors could lead to burnout as well as reduced empathy and compassion in midwives (Mayra, Matthews & Padmadas, 2022:2) and even harsh treatment, which would cause emotional harm to the labouring women. Being ignored by midwives who do not give them time would also be a form of abuse (Rominski *et al.*, 2017:216) leading to a negative birth experience. Therefore, the following recommendations were developed.

The caring behaviour “knowing” in midwives depends on various criteria, which indicate that they need to do the following:

- Conduct a thorough assessment of the woman’s subjective and unique needs, demands, expectations and feelings (Anderson *et al.*, 2020:6)
- Try to know the patients by observing, listening attentively to them and noting what they say as well as observing their non-verbal cues
- Have a respectful, empathic, compassionate, friendly and warm attitude when dealing with labouring women (Mårtensson *et al.*, 2022:1123; Kalfoss & Owe, 2015:979)
- Ask probing questions about how the woman is feeling and what has already occurred in during childbirth (Larsson & Hill, 2018:812; Swanson, 1991, 1993,1999)
- Focus on woman’s needs, demands, expectations and feelings (Larsson & Hill, 2018:812-14) by being physically and mindfully present/attentive

Midwives should therefore be cognisant that knowing and understanding a woman’s needs, choices and preferences are the key elements of caring behaviour that enhance a comfortable and dignified birthing process. The fulfilment of the above criteria would help midwives to attend to criteria of knowing women.

#### 5.3.5.4 *Criteria for knowing (unit managers)*

##### Background

The results of data analysis revealed that most of the respondents 97% (n=194) held a diploma in midwifery studies, indicating that they had the basic skills and knowledge in midwifery practice. However, the ICM (2017:4) emphasises that every midwife has the right to advanced midwifery education. Therefore, unit managers have to make sure that midwives obtain a degree in midwifery education. In addition, most of the respondents 40% (n=80) maintained that the selection of staff for professional development is inconsistent, which jeopardises their ability to provide the best healthcare during childbirth in line with current recommended midwifery practices (ICM, 2022:2-6; Munabi-Babigumira *et al.*, 2017:21; Bowser & Hill, 2010:5). Furthermore, unit managers had to provide opportunities for professional development to midwives. Therefore, the following recommendations were developed.

Unit managers would also need to demonstrate the caring behaviour “knowing” to enable midwives to develop it. However, the success of unit managers in doing this would depend on various criteria, which indicate that they should do the following:

- Strive to know the midwives’ working environment, skills, past/present performance, needs, demands and expectations to understand where there is room for improvement and to minimise factors inhibiting caring behaviour
- Improve midwives’ skills and competencies, as required by the ICM (2018:8-18), especially those needed for knowing their patients.
- Provide opportunities for professional development to midwives

Unit managers therefore need continuous upgrading for acquiring new skills and knowledge to advance their practical experience and confidence in providing care. Implementing these criteria will assist unit managers to fulfil the criteria for knowing.

#### 5.3.6 *Caring Behaviour 2: Being with*

##### 5.3.6.1 *Operational definition of being with*

The term “being with” refers to an individual’s physical and emotional presence, availability and closeness with another person (Mårtensson *et al.*, 2022:1125; Kalfoss



& Owe, 2015:977; Swanson, 1991:163, 1993, 1999). Therefore, in the context of midwifery, being with would involve midwives' physical and mental/emotional presence in the labour ward with labouring women whilst providing the care that they need.

#### 5.3.6.2 *Operational indicators of being with*

The operational indicators for being with are midwives' actions that show that they are present in mind and body with their female patients when needed. Midwives would demonstrate their ongoing availability to attend to their patients' physical and emotional needs. In addition, they would be close to the woman, thereby allowing them to share their feelings whether joyful or painful. They would also be proactive and cautious to avoid emotional harm (Kalfoss & Owe, 2015:979).

Midwives would establish a deeply caring relationship with the patient based on reciprocal and consistent bonding and attentiveness, which go beyond routine caring. Midwives would demonstrate sensitivity and empathetic insight into what the women are going through, by going a step beyond knowing. Their caring would be more than simply understanding the women's plight; it would involve being emotionally open to their patients' reality (Mårtensson *et al.*, 2022:1124).

#### 5.3.6.3 *Criteria for being with (midwives)*

##### Background

The results of the study show that most of the respondents 98.5% (n=197) indicated that the presence of midwives during childbirth makes the women feel valued, honoured and cared for with dignity and respect (Swanson 1991:163,1993). However, the results also showed that most of the respondents 86% (n=173) indicated that midwives' willingness and commitment to be with the labouring woman was inhibited by a poor working environment, a shortage of staff and work overload. As a result, they have limited time to be with the woman to meet and fulfil their needs and expectations. The less the enabling the working environment, the less the productivity (Mayra *et al.* 2021:6; Weldearegay *et al.* 2020:15; & Munabi-Babigumira *et al.* 2017:15). Therefore, the following recommendations were developed.

The caring behaviour "being with" in midwives depends on various criteria, which indicate that midwives need to do the following:

- Be physically and emotionally present in the labour room with the woman, which is what most women want (Khresheh *et al.*, 2019:3)
- Create a calm environment to alleviate anxiety and fear (Kalfoss & Owe, 2015:979)
- Engage with and centre on the labouring woman (Mårtensson *et al.*, 2022:1123; Swanson, 1991:162; 1993, 1999a)
- Recognise the woman as a significant being by listening and showing respect for her feelings, rights and dignity (Khresheh *et al.*, 2019:4; Swanson, 1991:163, 1993; Rominski *et al.*, 2017:217; Khresheh *et al.*, 2019:4; Bowser & Hill, 2010:5)
- Share experiences of childbirth with the woman, although putting her feelings first and not burdening her with those of others
- Clearly explain instructions to the labouring woman, making sure that she understands them
- Reassure the woman about the birthing process in a friendly manner (Mårtensson *et al.*, 2022:1125; Swanson, 1991:162, 1993, 1999)
- Show the caring behaviour “being with” through non-verbal language, which includes body posture, facial expressions and tone of voice (Mårtensson *et al.*, 2020:2)

The fulfilment of the above criteria would help a woman to trust their midwives and to practise self-control during the birthing process (Khresheh *et al.*, 2019:4). The availability of midwives during childbirth is a significant characteristic of caring behaviour during childbirth.

#### 5.3.6.4 *Criteria for being with (unit managers)*

##### Background

Unit managers play a significant role in being with the midwives supporting and building their morale in all spheres. The study results show that most of the respondents 64.5% (n=129) indicated that a lack of verbal appreciation by the supervisors of their work marred their caring behaviour. They felt they were under-appreciated, under-valued and unsupported by the supervisors, which affected their autonomy and emotional well-being. Therefore, the following recommendations were developed.

Unit managers also need to demonstrate the caring behaviour “being with” to enable midwives to develop it. However, the success of unit managers in doing this would depend on various criteria, which indicate that they should do the following:

- Show your availability to midwives to recognise and alleviate a shortage of staff and thus inspire their morale and emotional wellbeing when caring for women during childbirth (Mortenson *et al.*, 2022:1124; Munabi-Babigumira *et al.*, 2017:15)
- Prove to midwives that their experience is important, showing genuine interest and sharing feelings with them after a difficult situation as a key element of a willingness to provide holistic support that addresses the psycho-social needs of midwives during childbirth (Swanson, 1991; Bradley *et al.* 2019:2)
- Strive for empathetic insight into what the midwives are going through (Kalfoss & Owe, 2015:979)
- Use calm words and gestures when interacting with midwives to show sensitivity

Unit managers should stimulate and anchor caring behaviour through supportive management, in order to fulfil the criteria for being with.

### **5.3.7 Caring Behaviour 3: Doing for**

#### **5.3.7.1 Operational definition of doing for**

The caring behaviour “doing for” is performing an action for another that an individual would do for him/herself if possible (Mårtensson *et al.*, 2022:1125; Swanson, 1991:164; 1993, 1999). Therefore, in the context of midwifery, doing for would involve midwives continuously acting respectfully and skilfully and being highly committed to ensuring that the labouring woman experiences comfort, respect, trust and hope.

#### **5.3.7.2 Operational indicators for doing for**

The operational indicators for doing for include midwives’ actions that show that they are performing their duties to ensure a positive and dignified experience for the labouring woman (Kalfoss & Owe, 2015:977; Swanson 1991:164). Munabi-Babigumira *et al.* (2017:5) emphasise that skills development enables midwives to

provide holistic care, whilst Mestdagh *et al.* (2019:2) focus on respect, trust, open-mindedness, commitment and responsibility, which encourage women to express their concerns.

#### 5.3.7.3 *Criteria for doing for (midwives)*

##### Background

Doing for entails midwives doing for the women what they would do for themselves if they were able. The priority for doing for is based on putting the needs and expectations of the women first as an involuntary commitment to the duty. The results of the study revealed that many respondents 90% (n=180) showed commitment and willingness in putting the needs of the woman first as an indication of doing for. However, the respondents indicated the following factors inhibiting their caring behaviour: a lack of equipment 92% (n=184), the demanding attitude of the woman 55% (n=110), the younger age of the woman (<15 years) 66% (n=132), the parity of the woman (first childbirth) 64.5% (n=129) and the negative attitude of the woman 86.5% (n=173). These factors jeopardised their abilities to care for the labouring woman with kindness, respect and dignity to meet their needs. Therefore, the following recommendations were developed.

The caring behaviour “doing for” in midwives depends on various criteria, which indicate that midwives need to do the following:

- Ensure that labouring women feel safe and comfortable during childbirth
- Treat women with respect and dignity to maintain their autonomy
- Voluntary commit to performing their duty and providing service to the women
- Creating opportunities for interaction and a good relationship with the women
- Put the woman’s needs and expectations first (Larsson & Hill 2018:812-815; Khresheh & Barclay, 2019:71) as opposed to the midwives’ needs
- Stay on duty to complete work after the shift has ended as a significant characteristic of work commitment and willingness to care for the woman to the end
- Touch the labouring woman caringly to calm her and help her to control herself during childbirth pains by performing practical tasks, such as a back rub or massage, which the woman would do for herself if it were possible

Midwives should be mindful of performing activities that a labouring woman would do for herself if possible, and thus makes them feel valued and honoured during the birthing process. Mårtensson *et al.* (2022:2) and Swanson (1991; 1993; 1999) maintain that continuous hands-on support during childbirth enables labouring women to manage it effectively. Should midwives implement the recommendations, they would adhere to the criteria of doing for.

#### 5.3.7.4 Criteria for doing for (unit managers)

##### Background

The unit managers need to do for midwives as they would do for themselves if it were possible. The results of the study revealed that the majority of midwives reported several factors inhibiting them from doing their best to meet the labouring woman's demands and preferences during childbirth, for example, a shortage of staff 98% (n=196), work overload 96.5% (n=193), inadequate spacing and poor working environment 86% (n=172), a lack of verbal appreciation by supervisors 64.5% (n=129), an inconsistent selection of staff for professional development 73% (n=146) and a lack of equipment 92% (n=184). Moreover, these factors inhibit midwives' ability to meet professional standards of care and the woman's needs and expectations during childbirth. Therefore, the following recommendations were developed.

Unit managers would also need to demonstrate the caring behaviour "doing for" to enable midwives to develop this it. However, the success of unit managers in doing this would depend on various criteria, which indicate that they should do the following:

- Ensure that there are adequate resources and space in the workplace
- Ensure adequate staffing of the unit and sufficient midwives on duty to avoid work overload and burnout (Mayra *et al.*, 2022:6; Weldearegay *et al.*, 2020:15)
- Make equipment available for the effective provision of care during childbirth (Munabi-Babigumira *et al.*, 2017:15)
- Respond to emergencies by providing sufficient personnel because a favourable work environment plays a significant role in shaping health providers' ability to promote respectful maternity care (Bradley *et al.* 2019:3; Munabi-Babigumira *et al.* 2017:16; Ndwiga *et al.* 2017:8-11)

- Anticipate when midwives need support. A conducive atmosphere enhances interpersonal interaction that encourages emotional attachment and openness during childbirth (Al-Maharma *et al.*, 2021:2); Khresheh *et al.*, 2019:70); Larsson & Hill, 2018: 814).
- Establish a motivational reward system to uplift midwives' morale (Weldearegay *et al.* 2020:9; Mestdagh *et al.*'s 2019:5; McMahon *et al.* 2018:2); Munabi-Babigumira *et al.*, 2017:5).
- Build staff morale in all spheres
- Ensure that midwives received intimate caring support with respect and dignity that will motivate them to go beyond their routine work scheduled
- Continuously upgrade midwives' skills and knowledge to advance their practical experience and confidence in providing care because innovative caring behaviour is seen in people with advanced skills and knowledge

Unit managers should create a conducive work environment for midwives and the effective provision of care during childbirth. Should the recommendations be implemented, the criteria doing for would be addressed by unit managers.

### **5.3.8 Caring Behaviour 4: Enabling**

#### **5.3.8.1 Operational definition of enabling**

The caring behaviour “enabling” is facilitating the capacity of another individual to cope with a life transition or an unfamiliar event (Swanson, 1991:164, 1999b). Enabling would involve a midwife giving the labouring woman explicit information, instructions and explanations to help her to understand and cope with childbirth and develop self-care and determination, which would promote a positive birthing experience (Mårtensson *et al.*, 2022:1125; Kalfoss & Owe, 2015:977).

#### **5.3.8.2 Operational indicators for enabling**

The operational indicators for enabling are midwives giving clear information, instructions and explanations to the labouring woman so that she understands and copes with childbirth (Swanson, 1991:164). Midwives should allow alternative interventions that are acceptable to them and the women, such as the services of a doula or a partner/companion as an indication of respect for and recognition of the labouring women's preferences and demands. The midwife's success in creating a

calm atmosphere to enable the woman to cope with the birthing process would be another indicator.

#### 5.3.8.3 *Criteria for enabling (midwives)*

##### Background

The midwives in the study were aware that sharing clear information with the women enables them to understand and obey the instructions given during childbirth. Weldearegay *et al.*, (2020:16) Rominski *et al.*, (2017:222) and Dzomeku *et al.* (2018:7) maintain that effective communication and information-giving ensure that every labouring woman and her family or relatives know what is happening and what to expect during childbirth. The study results revealed that most of the respondents 99% (n=195) indicated that clearly explaining instructions enable the labouring woman to cope with childbirth. However, various factors inhibit the caring behaviour of midwives, which inspired a labouring woman to cope: a language barrier between the midwife and the woman 48% (n=96); inconsistent use of protocols 47% (n=94), the demanding attitude of the woman 55% (n=110). the parity of the woman (first childbirth) (64.5%, n=129) and the negative attitude of the labouring woman 86.5% (n=173). Therefore, the following recommendations were developed.

The caring behaviour “enabling” in midwives depends on various criteria, which indicate that midwives need to do the following:

- Motivate the labouring woman to practice self-control and be positive/hopeful (Mårtensson *et al.*, 2022:1125; Kalfoss & Owe, 2015:98)
- Inform, explain, give instructions and update the woman on her progress, thereby enabling her to feel in control of the birthing process and satisfied with the care (Anderson *et al.*, 2021:6)
- Involve the woman and her family in her care to make them aware of the intended outcomes of procedures and/or decisions about her care (Dzomeku *et al.*, 2018:7)
- Demonstrate a willingness to share power and responsibility with the woman would build and enhance a labouring woman’s self-confidence and determination (Mayra *et al.*, 2020:8; & Bradley *et al.*, (2019:2)

- Show warmth and compassion by allowing family members to assist to enable the woman to feel safe and secure during childbirth (Mestdagh *et al.*, 2019:1; Swanson, 1991:164,1999b)
- Creating a calm environment that facilitates the recognition of the woman's needs and rights as well as mutual dependence (Mestdagh *et al.*, 2019:1; Lohmann *et al.*, 2018:58)

Conveying intimate caring support, thereby ensuring that the labouring woman receives the highest standard of care during childbirth and feels respected, dignified and valued by her midwife is central to adhering to the criteria for enabling by midwives.

#### 5.3.8.4 *Criteria for enabling (unit managers)*

##### Background

The results of the data analysis revealed that the respondents reported that a lack of equipment 92% (n=184) and insufficient verbal appreciation by supervisors of their work 64.5% (n=129) were factors inhibiting their caring behaviour and led to emotional stress, burnout and low morale. Therefore, it is the responsibility of the unit manager to foster a safe and conducive working environment for midwives. consistently to enable the delivery of quality maternal healthcare (Ndwiga *et al.*, 2017:11) and work satisfaction. Therefore, the following recommendations were developed.

Unit managers would also need to demonstrate the caring behaviour “enabling” to help midwives to develop it. However, the success of unit managers in doing this would depend on various criteria, which indicate that they should do the following:

- Support and develop midwives' autonomy by conveying appreciation for the work done
- Provide opportunities for continuous upgrading of old knowledge/skills and acquiring new ones to advance their practical experience and confidence in providing care (Weldearegay *et al.*, 2020:9); Mestdagh *et al.*, 2019:5; McMahon *et al.*, 2018:2); Munabi-Babigumira *et al.*, 2017:5)
- Facilitate midwives' willingness to share power and responsibility with colleagues and labouring women to strengthen their acceptance of assistance



and support from one another (Mayra *et al.*, 2020:8; Mestdagh *et al.*, 2019:1; Lohmann *et al.*, 2018:58; Ndwiga *et al.*, 2017:8)

- Share responsibility with midwives to build their confidence

Unit managers including midwives in decision-making about woman's care during childbirth with no intimidation or humiliation is fundamental in ensuring that the criteria of enabling are implemented.

### **5.3.9 Caring Behaviour 5: Maintaining belief**

#### **5.3.9.1 Operational definition of maintaining belief**

The caring behaviour "maintaining belief" is sustaining faith in an individual's capacity to cope with an event or transition and face the future (Mårtensson *et al.*, 2022:1125; Kalfoss & Owe, 2015:982; Swanson. 1991:165,1993, 1999b). This means that a midwife would convey a sense of hope, trust and concern to the labouring woman so that she feels safe, comfortable and positive that she will manage the childbirth successfully.

#### **5.3.9.2 Operational indicators of maintaining belief**

The operational indicators for maintaining belief are actions that indicate that the midwife is sustaining hope and faith in the patient and believing in the labouring woman's ability to cope with childbirth. This refers to the midwife's realistic but hope-filled attitude that would eradicate any sense of hopelessness in his/her patient (Mårtensson *et al.*, 2020:1125; Swanson, 1991:165,1993,1999a).

#### **5.3.9.3 Criteria for maintaining belief (midwives)**

##### **Background**

Midwives, by conveying a sense of hope, trust and concern assist the labouring women to feel safe and comfortable. Moreover, they should strive to know, be with, do for and enable the women to fulfil their demands during childbirth. The study's results showed that most of the respondents identified the behaviour, which would indicate caring in the sense of maintaining belief in the woman's ability to manage her labour and face the birthing process with determination and confidence. This behaviour involved showing genuine interest 94.5% (n=189), attending to the woman's demanding needs 91% (n=182), creating a calm atmosphere 99.5%

(n=199) and providing privacy (99%, n=198). Therefore, the following recommendations were developed.

Maintaining belief in midwives depends on various criteria, which indicate that midwives need to do the following:

- Verbally and non-verbally express faith in the labouring woman's ability to deliver the baby
- View the labouring woman as a person who deserves respect as a unique individual who is capable of coping with childbirth (Kalfoss & Owe, 2015:982)
- Assist the labouring woman in finding meaning in the birthing process (Mårtensson *et al.*, 2022:1130)
- Build the woman's strength by motivating and supporting her during childbirth
- Make positive statements to convey a sense of hope, safety and trust that all will be well for the labouring woman

Midwives have the power to ensure that labouring women attain the highest standard of maternal care in facility-based childbirth, which would maintain their trust and hope-filled believe about midwives. By implementing these criteria, midwives could ensure that the criteria for maintaining belief are adhered to.

#### 5.3.9.4 *Criteria for maintaining belief (unit managers)*

##### Background

Unit managers are responsible for fostering an environment that supports diverse individuals' perspectives and creativity by ensuring fairness, dignity and compassion in the workplace. Moreover, they should provide opportunities for professional development. The results showed that most of the respondents reported factors that inhibited caring behaviour due to management's failure to maintain belief in the sense of believing in the midwives' ability to provide quality care. Examples include the inconsistent selection of staff for professional development 73% (n=146); insufficient verbal appreciation by supervisors 64.5% (n=129); and the educational of midwives remaining at the level of a diploma in midwifery 97% (n=194), (Mestdagh *et al.*, 2019:5; Lambert *et al.*, 2018:41; Munabi-Babigumira *et al.*, 2018:5). Moreover, a lack of staff development, support and appreciation negatively affects work performance. As emphasised by the ICM (2022:4-6) and Munabi-

Babigumira *et al.* (2017:4), every midwife has the right to midwifery-specific education that could enable him/her to develop and maintain competency as a midwife. Therefore, the following recommendations were developed.

Unit managers would also need to demonstrate the caring behaviour of “maintaining belief” to help midwives to develop this caring behaviour. However, the success of unit managers in doing this would depend on various criteria, which indicate that they should do the following:

- Show respect for and trust in the midwives’ capabilities because they have the knowledge and skills required for ethical best practices during childbirth (ICM, 2018:195-200; Republic of Botswana, 1995:15-21)
- Build midwives’ autonomy by sharing responsibility and power in decision-making about women’s needs and expectations during childbirth (Mårtensson, 2020:1124; Swanson, 1991, 1993, 1999)
- Verbally value the midwives’ worth and offer words of appreciation, which will encourage midwives’ caring behaviour (Larsson & Hill, 2018:813; Mukamurigo *et al.*, 2017:9)
- Establish a performance reward system, such as verbal or written appreciation of work done, access to in-service training and consistent selection of staff for professional development, which will result in proficiency and awareness of appropriate clinical practice (Bradley *et al.*, 2019:3; Khresheh *et al.*, 2019:76; Munabi-Babigumira *et al.*, 2017:4-20; Ndwiga *et al.*, 2017:8-11)
- Create and regularly communicate a framework for success to organise opportunities for professional development – for example, adequate in-service education and selection for professional development

Unit managers have a responsibility to convey a sense of hope and trust in the midwives so that they can feel confident and encouraged to cope with all the situations they face when caring for women during childbirth. By implementing these recommendations, unit managers can adhere to the criteria of maintaining belief.

#### **5.4 Summary of the chapter**

This chapter presented a summary of the research results and provided recommendations for midwives and unit managers to optimise the caring behaviour of

midwives in Botswana, which were informed by the results and Swanson's (1991) caring processes: caring: knowing, being with, doing for, enabling and maintaining belief, which should be followed by midwives and midwifery unit managers.

The next chapter concludes the study by summarising the research objectives, design, methods and research results, presenting conclusions, discussing the strengths and weaknesses of the study and making recommendations for midwifery practice, education and research.

## CHAPTER 6

### SUMMARY, CONCLUSION, STRENGTHS/LIMITATIONS AND RECOMMENDATIONS

#### 6.1 Introduction

The previous chapter presented the design and development of recommendations for midwives and unit managers based on the research results and Swanson's (1991) Theory of Caring. This chapter summarises the research objectives; the research design and method; and the research results. Moreover, it presents conclusions, discusses the strengths and limitations of the study and provides recommendations for midwifery practice, education and research.

#### 6.2 Summary

##### 6.2.1 *Research objectives*

The objectives of the study were to do the following:

- Identify and describe the caring behaviour of midwives in Botswana
- Determine the factors that inhibit the caring behaviour of midwives in Botswana
- Make recommendations for midwives and unit managers that could be used to optimise the caring behaviour of midwives in Botswana

##### 6.2.2 *Research design and methods*

A quantitative descriptive research design was followed to answer the first two research questions. The data collection method comprised a survey using a structured, self-administered questionnaire developed by the researcher to gather data from purposively selected professional midwives working at the maternity units of Kgatleng and Greater Gaborone DHMTs. Before the data collection, a pilot study was conducted to test the measuring instrument (the questionnaire) the results of which revealed that the questionnaire sufficiently and effectively solicited the desired data.

The target population, which was also the sample, was 250 professional midwives who were eligible to participate because they met the inclusion and exclusion criteria.,

However, only 200 professional midwives completed the questionnaire, thereby achieving a response rate of 80%. The raw data from the completed questionnaires were prepared, organised and captured by the researcher on Microsoft Excel® spreadsheets. Furthermore, the data were transferred to statistical data analysis software with the assistance of a statistician from Nelson Mandela University. All analyses were performed using SPSS®, Version 27. The level of significance was set at  $p < 0.05$ . The results of the data analysis were presented in the form of tables and diagrams representing the respondents' answers to the questions in the questionnaire.

### **6.2.3 Results of the data analysis**

The following sections summarise the results of the statistical analysis of the data gathered from the midwives who participated in the study.

#### **6.2.3.1 Respondents' demographics**

The results of the analysis of the data on the respondents' demographics gathered in Section A of the questionnaire were presented, interpreted and discussed in light of the literature in Chapter 4. These results are summarised below.

Of the 200 respondents, most were aged between 40-49 years 40.5% ( $n=81$ ), were female 92% ( $n=184$ ) and had a diploma in nursing and midwifery 97% ( $n=194$ ). In addition, most of the respondents had 6 to 10 years of work experience as a midwife 31% ( $n=62$ ) and had more than five years of experience in the same unit/ward. In addition, 36% ( $n=73$ ), were working in the clinics with a maternity unit 58% ( $n=116$ ) and were satisfied with their work 94% ( $n=188$ ).

#### **6.2.3.2 Midwives' caring behaviour**

The data gathered in Section B of the questionnaire were analysed to identify and describe the caring behaviour of midwives. Of the 21 statements to which respondents had to respond, all were agreed to by most of the participants by far. Some received responses indicating disagreement and all received a few neutral responses. However, the most neutral responses were directed at the following caring behaviour: arranging for the woman in labour to see her relatives; respecting the woman's preferences; keeping relatives informed about the woman; and staying at work after a shift has ended. These results informed the recommendations for midwives and unit managers to optimise caring behaviour explained in Chapter 5.

#### **6.2.3.3**      *Factors inhibiting midwives' caring behaviour*

The data gathered in Section C of the questionnaire were statistically analysed and the results were presented, interpreted and discussed in light of the literature in Chapter 4. Of the 22 statements, the following were identified as inhibiting factors: a shortage of staff; a heavy workload; a poor working environment; a lack of equipment; the young age of labouring women (<15 years); parity (first childbirth); and the negative attitude of the woman.

### **6.3 Conclusions**

The study outcomes revealed that most of the respondents agreed with the questionnaire statements on caring behaviour. This suggests that they might have successfully demonstrated caring behaviours to ensure that their patients had a positive and dignified childbirth experience and could cope with the birthing process. However, a few respondents did not agree with some statements on caring behaviour, which suggests that they might not have demonstrated caring behaviour in compliance with the midwifery guidelines on acceptable standards of maternal care. Therefore, the research developed recommendations for optimising the caring behaviour of midwives based on Swanson's (1991) Theory of Caring, which underpinned the study with its five processes: knowing, being with, doing for, enabling and maintaining belief.

The recommendations are meant to inform midwives, unit managers, management, lecturers, researchers, staff and student midwives of what could be done to optimise the caring behaviour of midwives.

### **6.4 Strengths and limitations of the study**

The study has several strengths and limitations, which are discussed below.

#### **6.4.1 Strengths**

- Midwives' caring behaviour was captured in the study
- A reasonable sample size was possible because all the potential respondents were eligible to participate.
- This was the first study on midwives' caring behaviour in the context of Botswana.

#### **6.4.2 Limitations**

- The study population was drawn solely from public institutions, thereby neglecting private institutions.
- The study was limited to midwives working in maternity units, thereby ignoring those in other units.

#### **6.5 Recommendations**

The recommendations should be shared with professional midwives, unit managers and other stakeholders to optimise the caring behaviour of midwives in Botswana. Moreover, the recommendations are relevant to midwifery practice, education and research.

##### **6.5.1 Recommendations for midwifery practice**

- Provide in-service training, lectures and workshops to inform professional midwives and unit managers about the study recommendations guided by Swanson's Theory of Caring to optimise antepartum, intrapartum and postpartum caring behaviour
- Use the five recommended caring processes as an assessment tool for clinical audits, quality improvement projects and standard operating procedures (SOPs) at the midwives' place of work to investigate caring behaviours
- Use the recommendations in Chapter 5 as a tool for continuous professional development at the workplace, mentoring and simulations for midwifery practice
- Include research results and recommendations in the continuous professional assessment required for practising midwives by the nursing and midwifery council of Botswana
- Include information on midwives' caring behaviour in midwifery workshops, seminars and symposia
- Adopt Swanson's (1991) Theory of Caring or another theory in health facilities caring theory to guide midwifery practice to meet women's expectations efficiently



- Use the research results to develop caring behaviour that increases the interaction of midwives in Botswana with women during labour

#### **6.5.2 *Recommendations for midwifery education***

- Use the research outcomes to enhance the teaching and learning of caring behaviour to future midwives during their pre-service training
- Use the research results to inform programme development and the midwifery curriculum with some modification, particularly in midwifery education in Botswana
- Use the research outcomes to guide observations or simulations during the practical part of clinical teaching and learning
- Include more midwives in advanced midwifery education

#### **6.5.3 *Recommendations for midwifery research***

- Conduct research on professional midwives in the other eight administrative districts in Botswana (apart from Kgatleng and Greater Gaborone) to generalise the results to a wider population
- Conduct research on all health professionals providing antepartum, intrapartum and postpartum care, as the current study focussed on midwives working in maternity units
- Repeat the study in public health facilities, such as referral/district hospitals and clinics with maternity units
- Conduct a qualitative study to investigate the perceptions of women who have given birth or are of the caring behaviour of midwives in Botswana and explore
- Investigate other factors that hinder midwives' caring behaviour and jeopardise midwifery practice

### **6.6 Summary of the chapter**

This chapter has explained that despite the study's weaknesses, the research objectives were met, which indicated that many respondents were able to identify the caring behaviour expected of midwives. Moreover, respondents identified factors that inhibit the caring behaviour of midwives, which might lead to a lack of quality care. Therefore, eliminating these inhibiting factors along with following the recommendations would promote caring behaviour in midwives.

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# ANNEXURES

## Annexure A: Letter from RECH (Nelson Mandela University)



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Ref: [H20-HEA-NUR-010 / Approval]

19 February 2021

Mr I Sonti  
Faculty: Health Sciences

Dear Mr Sonti

### **CARING BEHAVIOURS OF MIDWIVES WHO NURSE WOMEN DURING CHILDBIRTH IN BOTSWANA**

PRP: Mr I Sonti  
PI: Ms N Potokwane

Your above-entitled annual progress report (APR) was reviewed by REC-H EXCO for approval. We take pleasure in informing you that the Research Ethics Committee (Human) has approved your report. Please note the following as you continue your study to its completion:

1. In the event of a requirement to extend the period of data collection (i.e. for a period in excess of 1 calendar year from date of original approval of study), completion of an extension request is required (form RECH-005 available on Research Ethics Committee (Human) portal)
2. In the event of any changes made to the study (excluding extension of the study), completion of an amendments form is required (form RECH-006).
3. Immediate submission (and possible discontinuation of the study in the case of serious events) of the relevant report to RECH (form RECH-007) in the event of any unanticipated problems, serious incidents or adverse events observed during the course of the study.
4. Immediate submission of a Study Termination Report to RECH (form RECH-008) upon expected or unexpected closure/termination of study.
5. Immediate submission of a Study Exception Report of RECH (form RECH-009) in the event of any study deviations, violations and/or exceptions.
6. Acknowledgement that the study could be subjected to passive and/or active monitoring without prior notice at the discretion of Research Ethics Committee (Human).

Please inform the REC-H, via your faculty representative, if any changes (particularly in the methodology) occur during this time (forms as above). An annual affirmation to the effect that the protocols in use are still those for which approval was granted, will be required from you.

Please quote the ethics clearance reference number in all correspondence and enquiries related to the study. For speedy processing of email queries (to be directed to [imtiyaz.khan@mandela.ac.za](mailto:imtiyaz.khan@mandela.ac.za)), it is recommended that the ethics clearance reference number together with an indication of the query appear in the subject line of the email.

We wish you well with the continuation of your study.

Yours sincerely



**Dr S Govender**  
Chairperson: Research Ethics Committee (Human)

Cc: The Office of Research Development  
Faculty Officer: Health Sciences

## Annexure B: Letter to the Botswana Ministry of Health and Wellness



Summerstrand

Port Elizabeth

South Africa

6001

20 September 2020

The Permanent Secretary

Ministry of Health and Wellness

Private Bag 0038

Gaborone

Botswana

Telephone: (+267) 363 3500

Fax: (+267) 391 0647

Dear Sir/Madam

### **REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY IN PRIMARY HEALTH CARE CLINICS/HOSPITAL MATERNITY UNITS.**

I, Nancy Osupile Potokwane, am a research master's degree student in the department of Advanced Midwifery and Neonatal Nursing Science at Nelson Mandela University, Port Elizabeth, South Africa. I plan to research a topic with the title: *Caring behaviours of midwives who nurse women during childbirth in Botswana.*

I hereby request your consent to conduct a research study on professional midwives working in the primary health care clinics/hospital maternity units in the Kgatleng and Greater Gaborone District Health Management Teams. The findings of the study will assist the researcher in making recommendations for midwives and unit managers, which could be used to optimise midwives' caring behaviour towards women during labour and childbirth.

This project will be conducted under the supervision of Mr Israel Sonti at Nelson (supervisor) and Dr Lourett Smith (co-supervisor) at Nelson Mandela University, Port Elizabeth, South Africa.

The objectives of the study will be to

- Identify and describe the caring behaviour of midwives who nurse women during childbirth in Botswana
- Determine the inhibiting factors in the caring behaviour of midwives who nurse during childbirth in Botswana
- Make recommendations for midwives and unit managers that could be used to optimise the caring behaviour of midwives when nursing women during childbirth in Botswana.

The two districts have been purposively selected because the principal investigator mainly works there, they are the busiest districts, they are known to handle a lot of births, and they demonstrated the attributes of the phenomenon under study.

The participation of midwives in the study will be voluntary, and they will not be coerced. In addition, there are no foreseeable risks associated with this study, and respondents may decide to withdraw from the study at any time without penalty if they feel uncomfortable. Their names will not be identifiable or used in any written reports. Furthermore, all information obtained will be anonymous and treated with utmost confidentiality. Furthermore, a written copy of the research outcomes will be shared with the respondents upon completion of the study.

The study has been approved by the Nelson Mandela University Research Ethics Committee – Human (REC-H), and I have attached a copy of the ethical approval letter (number:(H20-HEA-NUR-010). You may email the Committee if you have questions or concerns about the study using the following addresses:

ResearchEthics@mandela.ac.za or Imtiaz.Khan@mandela.ac.za

The researcher is cognizant of the COVID-19 pandemic that could have an impact on the interaction with the respondents that requires in-person engagement. Therefore, the national health recommended protocols and regulations will be adhered to throughout the study.

For further information, please do not hesitate to contact my supervisors at the following email addresses:

isonti@mandela.ac.za or louretts@mandela.ac.za

Or you may contact the researcher:

Cell: +27738428964/+26771472568/73929983

Email: s208022684@mandela.ac.za

Thank you in advance for your time and utmost cooperation.

Yours sincerely,



Nancy Osupile Potokwane

## Annexure C: Application for approval to conduct human research in Botswana

Ministry of Health



Republic of Botswana

### Application for Approval of Human Research

#### **Section A: Instructions**

1. For research/academic institutions or PHD students attach:
  - a) 14 copies of the Research Application form
  - b) 4 copies of the following:
    - i. Study proposal.
    - ii. Consent/authorization form or a request for waiver of consent/authorization- Setswana, English and back translation where applicable.
    - iii. Questionnaires are to be used. Setswana, English and back translation where applicable.
    - iv. Curriculum vitae/ resume of each member of the Research team
    - v. Approval letter from other IRBs
    - vi. Grant approval letter
    - vii. Any other supporting materials i.e. recruitment scripts, brochures, flyers etc.
2. For undergraduates and graduates attach one copy of the above-listed items/ documents.

#### **Section B: Application Details**

1. Study Title: (Include Version number and date)  <b><i>Caring behaviours of midwives who nurse women during childbirth in Botswana</i></b>	
2. Date of submission <b>15/September/2020</b>	
3. Type of Research:  <ol style="list-style-type: none"><li>i. Basic Science - <b>No</b></li><li>ii. Public Health - <b>No</b></li><li>iii. Clinical Research - <b>Yes</b></li><li>iv. Human Biology - <b>No</b></li><li>v. Other: (specify) -<b>No</b></li></ol>	
4. Principal Investigator (Name & Qualifications):  <b>Nancy Osupile Potokwane</b>	4(i). Local Contact Details

Postal <b>53 Ivana Drive, Summerstrand</b> Address: <b>Port Elizabeth South Africa</b>	Postal Address: <b>P. Box 931 ABG Sebele, Gaborone Botswana</b>
Phone Number: <b>+27 73 842 8964</b>	Phone Number: <b>+267 73929983 / 71472568</b>
E mail Address: <b>s208022684@mandela.ac.za</b>	E mail Address: <u>s208022684@mandela.ac.za</u>
Name of affiliate: <b>Prof Sindiswa James</b> Institution/Organisation: <b>Nelson Mandela University</b>	Name of Institution/Organisation: <b>Ministry of Health and Wellness</b>
Department: <b>Nursing Science</b>	Department ( <i>If Government</i> ): <b>Clinical Services</b>

#### 5. Other Investigators /Co-Principal Investigators

Name:	Organisation:	Email:	Telephone Number:
Mr Israel Sonti	Nelson Mandela University	<u>israel.sonti@mandela.ac.za</u>	+27415042674
Dr Lourett Smith	Nelson Mandela University	<u>lourett.smith@mandela.ac.za</u>	+27415041288

#### 6. Key Personnel working with data that may be linked to human subjects

Name:	Organisation:	Email:	Telephone Number:
Nancy Osupile Potokwane	Ministry of Health and Wellness	<u>s208022684@mandela.ac.za</u>	+26773929983 +26771472568



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## Section C: Description of Research

### 1. Brief Description of Study

Caring behaviour is a fundamental psycho-social element that forms the core of midwifery care and practice. It involves good relations between the midwife and the labouring women. The midwife ought to show respect, kindness and emotional support towards women during childbirth. Despite caring being an important aspect of the health care system, the uncaring phenomenon continues to be a regrettable global concern in facility-based childbirth units. Women continue to experience uncaring practices and abuse during childbirth, such as verbal, non-verbal, physical abuse and non-consented care. Bohren *et al.* (2015:1) reveal that 19% to 28% of women experience uncaring treatment during childbirth in Low- and Middle- Income Countries. Such practices by midwives left women feeling disrespected absolute disgraced and profoundly humiliated (Khresheh, Barclay & Shoqirat, 2019:2). These findings are congruent with the study conducted by Mashira & Palamuleni (2017:30), which revealed that women who had been exposed to uncaring during childbirth tended to be reluctant to seek midwifery care at the unit and would be prone to post-partum traumatic stress; such as fear of giving birth. The United Nations Respectful Maternity Care Charter (2012:3-5) emphasises that disrespect of women during childbirth is a violation of human rights and that every woman has the right to the highest attainable standard of care during childbirth. Similarly, uncaring during childbirth also impose the maternal healthcare system challenged with litigations for malpractice of healthcare professionals (Spenser., du Preez & Minnie, 2018:5). Furthermore, women's complaints of abuse by midwives in maternity units impose a negative outcome on the attainable standards of Ministry of Health and Wellness; vision, mission and values (MoHW, 2011). Though, this study must seek to identify and describe the caring behaviour of midwives who nurse women during childbirth in Botswana. The findings will serve as scientific evidence towards addressing the concern to optimise the caring behaviour of midwives when nursing women during childbirth.

### 2. Rationale/Justification (*Why the need to carry out this study in Botswana*)

The purpose of the study will be to identify and describe the caring behaviour of midwives who nurse women during childbirth in Botswana. The acquired information will assist the

researcher to make recommendations for midwives and unit managers that could be used to optimise the caring behaviour of midwives when nursing women during childbirth in Botswana.

### 3. Study Objectives (*Both General and Specific*):

The proposed objectives of the study are to:

- I. identify and describe the caring behaviour of midwives who nurse women during childbirth in Botswana;
- II. determine inhibiting factors of the caring behaviour of midwives who nurse women during childbirth in Botswana; and
- III. make recommendations for midwives and unit managers that could be used to optimise the caring behaviour of midwives when nursing women during childbirth in Botswana.

### 4. Expected Results (*Both Primary and Secondary endpoints*)

I hope that the midwives and other health personnel might benefit from these study findings through improved understanding to optimise caring behaviour during childbirth. The study results might also assist policymakers to make an informed decision on improved promotion of respectful maternity care in facility-based childbirth units, ensuring that every woman experiences positive and dignified caring during childbirth in Botswana.

## **Section D. Methodology**

### **1. Study Design**

**The research design is the plan or road map on how the proposed study will be conducted. Research design determines the methodology to be used to describe the purpose of the study, the kinds of questions to be addressed and the technique to be used for data collection, sampling and sample size procedure and how the data will be analysed. The researcher will use a quantitative research method with a descriptive approach to identify and describe the caring behaviour of midwives who nurse women during childbirth in Botswana.**

### **2. Study sites (*Districts, Towns, Villages, Health facilities, Schools etc.:***

**The primary health care clinics and hospital maternity units in the Kgatleng and Greater Gaborone District Health Management Teams (DHMTs).**

### **3. Subject Population(s) (*Clinical condition, Gender, age, and other relevant Characteristics*):**

**The target population for the study will be professional midwives working in the primary health care clinics and hospital maternity units in the Kgatleng and the Greater Gaborone district health management teams, whose composition meets the specific set inclusion and exclusion criteria for the study.**

### **4. Sample size (*The number of subjects to be involved in the study and how these subjects will be selected from the population***

**Purposive sampling will be used to recruit all professional midwives working in the maternity units of the two districts who meet the inclusion and exclusion criteria of the study. The estimated minimum sample size will be 250 respondents necessary to make the study viable.**

**5. Subject Recruitment/Sampling Methods (*Explain all procedures in detail*):**

**Recruitment refers to the criterion of selecting study respondents' inclusion in a research study. A purposive sampling technique will be used to select Midwives working in the maternity units based on the set inclusion and exclusion criteria. The respondents must meet the following criteria:**

**The inclusion criteria will be midwives**

- **who are permanently working in maternity units in the Kgatleng and Greater Gaborone districts.**
- **who have six months or more of work experience in the particular units and**
- **who have valid midwifery practice license certificates with the Nursing and Midwifery Council of Botswana (NMCB)**

**The exclusion criteria will be:**

- **unit managers of maternity units because they are not actively caring for women during childbirth, and**
- **midwives who are working on a rotational or relieve basis in the unit.**

**6. Data Collection Methods (*Explain all procedures in detail*)**

**Data collection is the formal process of acquiring data from the study subjects in a standardised pattern. A self-administered structured questionnaire will be used to collect data. After obtaining ethical approval from the Nelson Mandela University's Departmental Research Committee, Faculty of Health Sciences Post-Graduate Studies Committee and the Research Ethics Committee-(Human), the researcher will write letters (See Annexures B and C) to the Permanent Secretary of the Ministry of Health and Wellness in Botswana requesting permission to conduct a research study on midwives working in maternity units of the two District Health Management Teams (DHMTs), Kgatleng and Greater Gaborone districts. The letter will be accompanied by the completed application form for approval to the Health Research and Development Committee in Botswana (See Annexure C), the approved research proposal, the approval letter to conduct the study and a copy of the ethical clearance letter from Nelson Mandela University Research Ethics-Human Committee for study number H20-HEA-NUR-010.**

**Upon obtaining approval from the gatekeepers, The Ministry of Health and Wellness (MoHW), Department of Health Research Ethics and Development Committee (HRDDC), the University of Botswana Health Research Committee which is an affiliating institution, Hospital Managers/superintendent and the DHMT's Coordinators. The HRDDC will offer the researcher permission to conduct the study under their supervision. However, the unit managers will assist the researcher to gain access to meet with the respondents to present a brief overview**

of the study to make an informed choice. Those who voluntarily agree to participate will be provided with a letter of request to participate in the study and required to sign an informed written consent form (Annexure G) to voluntarily participate in the study. The questionnaire (Annexure H) will be administered by the researcher and they will be required not to write their names on the questionnaire for anonymity and confidentiality. The questionnaire will take about 20 to 30 minutes to complete. All information obtained will be kept safe and well-protected under lock and key. The tool will have measuring variables which involve Sections A, B and C; and will have several answers from which to choose, using the five-point Likert scale. The data-collection process will take about two months.

**7. Data Analysis (*Briefly explain how data will be analyzed*)**

Data will be captured by the researcher precisely on a Microsoft Excel (MS Excel) spreadsheet for statistical analysis. The information will then be transferred to SPSS software for further analysis. The statistical data will be described, summarised and presented graphical either in bar graphs or pie charts for easy understanding to answer the research questions.

**8. Piloting/Pretesting (*Explain all procedures in detail*)**

The pilot study refers to a small-scale trial run of the proposed study, using a small sample of respondents who are representative of the study population, to test the study instruments for reliability and validity. Similarly, the researcher will conduct the pilot study to make sure that the questions asked are clear and will effectively solicit the desired information. The results of the pilot study will give the researcher insight in preparation for the larger-scale research study. The questionnaire will be tested on the estimated minimum number of 10 midwives drawn from the study population, actually to complete the questionnaire to determine the validity of the instrument. The ethical considerations will be maintained in the same way as in the main study. Test-retest will be used to measure the reliability of the instrument. Findings of the pilot study will not be included in the main proposed study but rather documented in the summary outcome of the entire study.

**9. Protection of Subjects (*Describe measures to protect subjects from and minimise the possible risk of harm, discomfort, or inconvenience*):**

The researcher will adhere to the Belmont Report principles relevant to conducting research involving human subjects, such as informed consent, respect for persons, beneficence and justice. The rights of the respondents will be protected, and the ethical principles will be discussed and observed throughout the study. A brief overview of the study will be presented to the respondents to make an informed choice. Their participation in the study will be completely voluntary. They will be required to sign an informed written consent to participate in the study and will be kept separate and well-protected under lock and key. Respondents will be free to withdraw from the study at any time without penalty or coercion. They will be required not to write their names on the questionnaire for anonymity and confidentiality. They will be allowed not to answer questions that they feel uncomfortable with. They will be free from harm or discomfort, and there are no foreseeable risks associated with this study. All information obtained from the respondents will be treated with the strictest confidence

10. Approximate Date Study Recruitment will begin: **November/December 2020**

11. Estimated Duration of the entire study: **Three years**

## **Section E: Subject Information**

### **1. Inclusion Criteria**

**The inclusion criteria will be midwives:**

- **who is permanently working in maternity units in the Kgatleng and Greater Gaborone districts**
- **who have six months or more of work experience in the particular units and**
- **who have valid midwifery practice license certificates with the Nursing and Midwifery Council of Botswana (NMCB)**

### **2. Exclusion Criteria:**

**The exclusion criteria will be:**

- **unit managers of maternity units because they are not actively caring for women during childbirth, and**
- **midwives who are working on a rotational or relieve basis in the unit.**

### **3. Does the study involve Vulnerable Groups? *(Tick all that Apply)?***

Elderly

Children

Pregnant women, fetuses, or neonates of uncertain viability or nonviable Prisoners Decisional Impaired persons Minority and indigenous groups Low Literacy Economically Disadvantaged Other _____ <b>N/A</b>
4. Does this study involve any use of a drug? <b>NO</b> . If yes, is the drug registered or given exemption status (IND studies) by the Drug Regulatory Unit in Botswana? <i>If yes attach proof</i> __ <b>N/A</b>
5. Reasonably foreseeable risk or discomforts to the subjects ( <i>list in detail</i> ): <b>N/A</b>
6. Who will cover Subject Injury-Related Costs?  i. Sponsor ii. Third-Party Payers iii. Subjects iv. <b>N/A</b> v. Other
7. Potential benefits to society and to subjects ( <i>do not include compensation</i> ):  <b>The findings of the study will assist the researcher to make recommendations for midwives and unit managers that could be used to optimise the caring behaviour during childbirth.</b>
8. Give details of Botswana based personnel that will be involved ( <i>Name, functions and qualifications</i> ):     
9. Any remuneration given to subjects? <b>NO</b> . If yes, specify:
10. Will the respondent incur any financial cost in this study? <b>NO</b> . If yes, specify:

## **Section F: Data Sources**

### 1. Sources of Data

- i. Focus Group(s) - **NO**
- ii. Interviews - **NO**

- iii. Questionnaires/Surveys - **Yes**
- iv. Census/Public Records - **NO**
- v. Human Biological Specimen –**NO** Archive – **NO** Prospectively Collected – **NO** Discharged – **NO** Stored Samples - **NO**
- vi. Medical Records - **NO**
- vii. Registers (e.g. TB register and Cancer register) - **NO**
- viii. Other – **N/A**

### **Section G. Study Details**

<p>1. Capacity Building (<i>how will the study build capacity in the country</i>)</p> <p><b>The study findings may assist the researcher to make recommendations for midwives and unit managers that could be used to optimise caring behaviour when nursing women during childbirth, through in-service training on strengthening midwives' skills and knowledge on the promotion of respectful maternity care in facility-based childbirth units. Ensuring that women experience positive and dignified caring during childbirth.</b></p>
<p>2. Dissemination (<i>How will the study findings be disseminated</i>)</p> <p><b>A seminar, workshop or in-service training will be conducted to which respondents, other nursing staff and stakeholders will be invited and with whom the results will be shared at the end of the study.</b></p>
<p>3. Other Ethical Body(ies) Involved in the review of the study</p> <p><b>The Nelson Mandela University Research Ethics Committee (Human)</b></p>

### **Section H: Sponsor Information**

1. Name of Sponsor: **Ministry of Health and Wellness**
2. Type of Sponsor:
  - i. Government - **Yes**
  - ii. Private Foundation - **No**
  - iii. Industry - **No**
  - iv. Internal - **No**
  - v. Other – **N/A**
3. Sponsor Contact Person: **Ms Naledi D. Nkai / Mr Morena Mosalagae (Training)**
4. Sponsor Contact Telephone: **+267 3170585**



**Section I: Contact Information:**

PI or other researchers for answers to questions about the study or research-related injuries( <i>You must offer at least two contacts</i> ):	The HRDC representative who can answer questions about their rights as research subjects
<b>Mr Israel Sonti</b> <b>Dr Lourett Smith</b>	Name: <b>S. Mosweunyane / K M Motlhanka</b> Head of Health Research Unit Ministry of Health Private Bag 0038 Botswana Tel: (+267) 3914467 Fax: (+267) 3914697

**Section J: Investigator's Statement**

<p style="text-align: center;">INVESTIGATOR'S STATEMENT OF ASSURANCE</p> <p>I promise to abide by existing relevant International Declarations and National procedures and guidelines when undertaking research involving human subjects within the Republic of Botswana and agree to:</p> <ol style="list-style-type: none"><li>1. Ensure that all studies conducted on human respondents are designed and conducted according to sound scientific and ethical standards within the framework of good clinical practice.</li><li>2. Report to the Health Research and Development Committee any information requested, serious or unexpected adverse events and any information related to national programs.</li><li>3. Unless an emergency treatment for patient care, obtain prior approval from the HRDC before amending or altering the scope of the project or implementing changes in the approved consent form(s).</li><li>4. Submit progress reports as required by the HRDC.</li></ol>
---

5. Maintain all documentation including consent forms and progress reports.
6. Ensure that all members of the research team are aware of their roles and responsibilities in this study.
7. Ensuring, in accordance with the duties outlined for each member, that all members of the team are fully utilized for tasks assigned to them.

Principal Investigator's Name: **Nancy Osupile Potokwane**

Principal investigator's Signature: **N.O.P** Date: **20/09/2020**

Principal Investigator's Position: **Nursing Officer 1**

Local Investigator's Name:

Local investigator's Signature: Date:

Local Investigator's Position:

After Completion

1. An electronic and hard copy of the report should be submitted to the Health Research Unit, Ministry of Health as well as other relevant Botswana Government Institutions/Organisations within 3 months of producing a bound report.
2. All continuing renewals should be submitted at least 6 weeks before the expiration.

**Section K. For Health Research Unit use ONLY.**

1. Date Received	6. Review Body <input type="checkbox"/> Health Research Unit <input type="checkbox"/> HRDC
2. Final Outcome	
3. Ref No:	
4. Expiration Date:	

7. Continuing renewals extension

Date 1 \_\_\_\_\_

Date 2 \_\_\_\_\_

Date 3 \_\_\_\_\_

8. Final Report Submission

Yes Date \_\_\_\_\_

No

## Annexure D: Letter of approval/permission from HRDDC

Phetlo e lebeletse  
gabane  
BOTSWANA  
SEREBE



REPUBLIC OF BOTSWANA

MINISTRY OF HEALTH AND WELLNESS

TEL: (+267) 093 3586  
FAC: (+267) 091 6667  
TELEGRAMS: MASONGWANA  
TELEX: 2016 GARE BO

REFERENCE NO: HPDME 13/18/1

28<sup>th</sup> October 2020

Health Research and Development Division

Notification of IRB Review: New application

Nancy Osupile Potokwane  
P O Box 931 ABG Sebele  
Gaborone  
Botswana

Dear Nancy Osupile Potokwane

Protocol Title: CARING BEHAVIOURS OF MIDWIVES WHO NURSE  
WOMEN DURING CHILDBIRTH IN BOTSWANA

HRU Approval Date:	28 October 2020
HRU Expiration Date:	27 October 2021
HRU Review Type:	Expedited Review
HRU Review Determination:	Approved
Risk Determination:	Minimal risk

Thank you for submitting new application for the above referenced protocol. The permission is granted to conduct the study.

This permit does not however give you authority to collect data from the selected sites without prior approval from the management. Consent from the identified individuals should be obtained at all times.

The research should be conducted as outlined in the approved proposal. Any changes to the approved proposal must be submitted to the Health Research and Development Division in the Ministry of Health for consideration and approval.

Furthermore, you are requested to submit at least one hardcopy and an electronic copy of the report to the Health Research, Ministry of Health and Wellness within 3 months of completion of the study. Approval is for academic fulfillment only. Copies should also be submitted to all other relevant authorities.

Continuing Review

Vision: A Healthy Nation by 2036.

Values: *Bocho, Egoty, Tseletse, Customer Focus, Teamwork, Accountability*



In order to continue work on this study (including data analysis) beyond the expiry date, submit a Continuing Review Form for Approval at least three (3) months prior to the protocol's expiration date. The Continuing Review Form can be obtained from the Health Research Division Office (HRDD), Office No. 7A.7 or Ministry of Health website: [www.moh.gov.bw](http://www.moh.gov.bw) or can be requested via e-mail from Mr. Kgomoiso Motlhanka, e-mail address: [kgmmotlhanka@gov.bw](mailto:kgmmotlhanka@gov.bw). As a courtesy, the HRDD will send you a reminder email about eight (8) weeks before the lapse date, but failure to receive it does not affect your responsibility to submit a timely Continuing Report form.

#### Amendments

During the approval period, if you propose any change to the protocol such as its funding source, recruiting materials, or consent documents, you must seek HRDC approval before implementing it. Please summarize the proposed change and the rationale for it in the amendment form available from the Health Research Division Office (HRDD), Office No. 7A.7 or Ministry of Health website: [www.moh.gov.bw](http://www.moh.gov.bw) or can be requested via e-mail from Mr. Kgomoiso Motlhanka, e-mail address: [kgmmotlhanka@gov.bw](mailto:kgmmotlhanka@gov.bw). In addition submit three copies of an updated version of your original protocol application showing all proposed changes in bold or "track changes".

#### Reporting

Other events which must be reported promptly in writing to the HRDC include:

- Suspension or termination of the protocol by you or the grantor.
- Unexpected problems involving risk to subjects or others
- Adverse events, including unanticipated or anticipated but severe physical harm to subjects.

If you have any questions please do not hesitate to contact Mr. K. Motlhanka at [kgmmotlhanka@gov.bw](mailto:kgmmotlhanka@gov.bw), Tel +267-3632751. Thank you for your cooperation and your commitment to the protection of human subjects in research.

Yours sincerely



Ms S. Morweunyane  
for **PERMANENT SECRETARY**



## Annexure E: Letters of request to conduct a study at the DHMTs



Summerstrand  
Port Elizabeth  
South Africa  
6001

30 November 2020

The Regional Coordinator  
Kgatleng Regional Health Management Team  
Mochudi  
Botswana

Dear Sir/Madam

### **REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY IN PRIMARY HEALTH CARE CLINICS/HOSPITAL MATERNITY UNITS.**

I, Nancy Osupile Potokwane, am a research master's degree student in the department of Advanced Midwifery and Neonatal Nursing Science at Nelson Mandela University, Port Elizabeth, South Africa. I plan to research a topic with the title: *Caring behaviours of midwives who nurse women during childbirth in Botswana.*

I hereby request your consent to conduct a research study on professional midwives working in the primary health care clinics/hospital maternity units in the Kgatleng and Greater Gaborone District Health Management Teams. The findings of the study will assist the researcher in making recommendations for midwives and unit managers, which could be used to optimise midwives' caring behaviour towards women during labour and childbirth.

This project will be conducted under the supervision of Mr Israel Sonti at Nelson (supervisor) and Dr Lourett Smith (co-supervisor) at Nelson Mandela University, Port Elizabeth, South Africa.

The objectives of the study will be to

- Identify and describe the caring behaviour of midwives who nurse women during childbirth in Botswana
- Determine the inhibiting factors in the caring behaviour of midwives who nurse during childbirth in Botswana
- Make recommendations for midwives and unit managers that could be used to optimise the caring behaviour of midwives when nursing women during childbirth in Botswana.

The two districts have been purposively selected because the principal investigator mainly works there, they are the busiest districts, they are known to handle a lot of births, and they demonstrated the attributes of the phenomenon under study.

The participation of midwives in the study will be voluntary, and they will not be coerced. In addition, there are no foreseeable risks associated with this study, and respondents may decide to withdraw from the study at any time without penalty if they feel uncomfortable. Their names will not be identifiable or used in any written reports. Furthermore, all information obtained will be anonymous and treated with the utmost confidentiality. Furthermore, a written copy of the research outcomes will be shared with the respondents upon completion of the study.

The study has been approved by the Nelson Mandela University Research Ethics Committee – Human (REC-H), and I have attached a copy of the ethical approval letter (number:(H20-HEA-NUR-010). You may email the Committee if you have questions or concerns about the study using the following addresses:

ResearchEthics@mandela.ac.za or lmtiaz.Khan@mandela.ac.za

The researcher is cognitive of the COVID-19 pandemic that could have an impact on the interaction with the respondents that requires in-person engagement. Therefore, the national health recommended protocols and regulations will be adhered to throughout the study.

For further information, please do not to hesitate to contact my supervisors at the following email addresses:

isonti@mandela.ac.za or louretts@mandela.ac.za

Or you may contact the researcher:

Cell: +27738428964/+26771472568/73929983

Email: s208022684@mandela.ac.za

Thank you in advance for your time and utmost cooperation.

Yours sincerely,

A handwritten signature in cursive script, reading "NO Potokwane".

Nancy Osupile Potokwane



Summerstrand  
Port Elizabeth  
South Africa  
6001

02 Dec 2020

The Regional Coordinator  
Greater Gaborone Regional Health Management Team  
Gaborone  
Botswana

Dear Sir/Madam

**REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY IN PRIMARY  
HEALTH CARE CLINICS/HOSPITAL MATERNITY UNITS.**

I, Nancy Osupile Potokwane, am a research master's degree student in the department of Advanced Midwifery and Neonatal Nursing Science at Nelson Mandela University, Port Elizabeth, South Africa. I plan to research a topic with the title: *Caring behaviours of midwives who nurse women during childbirth in Botswana.*

I hereby request your consent to conduct a research study on professional midwives working in the primary health care clinics/hospital maternity units in the Kgatleng and Greater Gaborone District Health Management Teams. The findings of the study will assist the researcher in making recommendations for midwives and unit managers, which could be used to optimise midwives' caring behaviour towards women during labour and childbirth.

This project will be conducted under the supervision of Mr Israel Sonti at Nelson (supervisor) and Dr Lourett Smith (co-supervisor) at Nelson Mandela University, Port Elizabeth, South Africa.

The objectives of the study will be to

- Identify and describe the caring behaviour of midwives who nurse women during childbirth in Botswana
- Determine the inhibiting factors in the caring behaviour of midwives who nurse during childbirth in Botswana
- Make recommendations for midwives and unit managers that could be used to optimise the caring behaviour of midwives when nursing women during childbirth in Botswana.

The two districts have been purposively selected because the principal investigator mainly works there, they are the busiest districts, they are known to handle a lot of births, and they demonstrated the attributes of the phenomenon under study.

The participation of midwives in the study will be voluntary, and they will not be coerced. In addition, there are no foreseeable risks associated with this study, and respondents may decide to withdraw from the study at any time without penalty if they feel uncomfortable. Their names will not be identifiable or used in any written reports. Furthermore, all information obtained will be anonymous and treated with the utmost confidentiality. Furthermore, a written copy of the research outcomes will be shared with the respondents upon completion of the study.

The study has been approved by the Nelson Mandela University Research Ethics Committee – Human (REC-H), and I have attached a copy of the ethical approval letter (number:(H20-HEA-NUR-010). You may email the Committee if you have questions or concerns about the study using the following addresses:

ResearchEthics@mandela.ac.za or lmtiaz.Khan@mandela.ac.za

The researcher is cognitive of the COVID-19 pandemic that could have an impact on the interaction with the respondents that requires in-person engagement. Therefore, the national health recommended protocols and regulations will be adhered to throughout the study.

For further information, please do not to hesitate to contact my supervisors at the following email addresses:

isonti@mandela.ac.za or louretts@mandela.ac.za

Or you may contact the researcher:

Cell: +27738428964/+26771472568/73929983

Email: s208022684@mandela.ac.za

Thank you in advance for your time and utmost cooperation.

Yours sincerely,

A handwritten signature in cursive script, reading "NO Potokwane".

Nancy Osupile Potokwane

Summerstrand  
Port Elizabeth  
South Africa  
6001

02 Dec 2020

The Hospital Superintendent  
Princess Marina Hospital  
Gaborone  
Botswana

Dear Sir/Madam

**REQUEST FOR PERMISSION TO CONDUCT RESEARCH STUDY IN THE  
HOSPITAL MATERNITY UNIT**

I, Nancy Osupile Potokwane, am a research master's degree student in the department of Advanced Midwifery and Neonatal Nursing Science at Nelson Mandela University, Port Elizabeth, South Africa. I plan to research a topic with the title: *Caring behaviours of midwives who nurse women during childbirth in Botswana*.

I hereby request your consent to conduct a research study on professional midwives working in the primary health care clinics/hospital maternity units in the Kgatleng and Greater Gaborone District Health Management Teams. The findings of the study will assist the researcher in making recommendations for midwives and unit managers, which could be used to optimise midwives' caring behaviour towards women during labour and childbirth.

This project will be conducted under the supervision of Mr Israel Sonti at Nelson (supervisor) and Dr Lourett Smith (co-supervisor) at Nelson Mandela University, Port Elizabeth, South Africa.

The objectives of the study will be to do as follows:

- Identify and describe the caring behaviour of midwives who nurse women during childbirth in Botswana
- Determine the inhibiting factors in the caring behaviour of midwives who nurse during childbirth in Botswana
- Make recommendations for midwives and unit managers that could be used to optimise the caring behaviour of midwives when nursing women during childbirth in Botswana.

The two districts have been purposively selected because the principal investigator mainly works there, they are the busiest districts, they are known to handle a lot of births, and they demonstrated the attributes of the phenomenon under study.

The participation of midwives in the study will be voluntary, and they will not be coerced. In addition, there are no foreseeable risks associated with this study, and respondents may decide to withdraw from the study at any time without penalty if they feel uncomfortable. Their names will not be identifiable or used in any written reports. Furthermore, all information obtained will be anonymous and treated with the utmost confidentiality. Furthermore, a written copy of the research outcomes will be shared with the respondents upon completion of the study.

The study has been approved by the Nelson Mandela University Research Ethics Committee – Human (REC-H), and I have attached a copy of the ethical approval letter (number:(H20-HEA-NUR-010). You may email the Committee if you have questions or concerns about the study using the following addresses:

ResearchEthics@mandela.ac.za or lmtiaz.Khan@mandela.ac.za

The researcher is cognitive of the COVID-19 pandemic that could have an impact on the interaction with the respondents that requires in-person engagement. Therefore, the national health recommended protocols and regulations will be adhered to throughout the study.

For further information, please do not to hesitate to contact my supervisors at the following email addresses:

isonti@mandela.ac.za or louretts@mandela.ac.za

Or you may contact the researcher:

Cell: +27738428964/+26771472568/73929983

Email: s208022684@mandela.ac.za


Thank you in advance for your time and utmost cooperation.

Yours sincerely,

A handwritten signature in cursive script, reading "NG Potokwane".

Nancy Osupile Potokwane

**Annexure F: Approval letters from DHMT coordinators, superintendent and hospital managers**

<p>PRIVATE BAG 6038 GABORONE BOTSWANA REFERENCE:</p>	 <small>REPUBLIC OF BOTSWANA</small> <b>MINISTRY OF HEALTH AND WELLNESS</b>	<p>TEL: (+267) 363 2590 FAX: (+267) 391 0547 TELEGRAMS: RABONGAKA TELEX: 2618 CARE BO</p>
--	--	---

<b>REFERENCE:</b> DRM 3/1/28 II	01 February 2021
---------------------------------	------------------

---

Ms. Nancy Osupile P. Mokwane  
Nelson Mandela University  
Summerstrand, Port Elizabeth  
South Africa  
6001.

Dear Madam

**REF: REQUEST TO CONDUCT RESEARCH STUDY ONNPRIMARY HEALTH  
CARE MATERNITY CLINICS/HOSPITAL MATERNITY UNIT**

Your letter dated 30<sup>th</sup> November 2020 refers.


Your request for permission to conduct a research study titled **"Caring Behaviours of Midwives who nurse women during child birth in Botswana"** is acceded to.


This approval is valid and in conformance with permission granted by the Health Research and Development Division in the Ministry of Health and Wellness effective 28<sup>th</sup> October 2020 until 27<sup>th</sup> October 2021.

This permits you access to Kgatleng RHMT Health facilities, but you need to ask respondents for their participation. It should also not disturb patient care in any manner during the visit.

---

*Vision: A Model of Excellence in Quality Health Services*  
*Values: Botho, Equity, timeliness, Customer Focus, Teamwork*

  
MINISTRY OF HEALTH AND WELLNESS

  
BOTSWANA

By a copy of this letter the In-Charges of facilities are informed of your intentions and asked to provide you access and support during your study.

Thank you.

Yours Faithfully



.....  
Dr. H. Farrar Otieno

**For/ Hospital Superintendent**

---

**Vision:** *A Model of Excellence in Quality Health Services*  
**Values:** *Botho, Equity, timeliness, Customer Focus, Teamwork*





TELEPHONE: 390 5793  
FAX: 31 88012  
TELEXIRAMN: RABONGAKA  
TELEX: 2818 CARE BD



Republic of Botswana

DISTRICT HEALTH MANAGEMENT TEAM  
PRIVATE BAG RW 004  
GREATER GABORONE

REFERENCE NO: GGDHMT 6/17/1 I (46)

30 March 2021

The Chairperson  
Research Ethics Committee (Human)  
Nelson Mandela University  
P. O. Box 77000  
Port Elizabeth  
South Africa



Dear Sir/Madam

**RE: PERMISSION TO CONDUCT RESEARCH STUDY IN THE PRIMARY  
HEALTH CARE MATERNITY CLINICS/UNITS IN THE GREATER GABORONE  
REGIONAL HEALTH MANAGEMENT TEAM**

This serves to let you know that permission is granted for Nancy Osupile Potokwane to carry out research study titled: **"Caring Behaviours of midwives who nurse women during childbirth in Botswana"**.

This permits her to go into different clinics, with maternity units in the Greater Gaborone. It should also not disturb patients care in any manner during the course of the visits.

By copy of this letter the Nurse In-Charges and other health care workers are informed of her intentions and asked to provide her access and support during her study.

Yours faithfully

.....*K. G. Moruisi*.....

K. G. Moruisi

**DISTRICT HEALTH MANAGEMENT TEAM - COORDINATOR  
GREATER GABORONE**

Cc: Nurses In-Charge  
Greater Gaborone Clinics (Maternity Units)

---

*Vision: A Healthy Nation by 2023.*

*Values: Batho, Equity, Timeliness, Customer Focus, Teamwork, Accountability.*



PLOT 1836 HOSPITAL WAY  
TELEPHONE: 3621400  
FAX: 3973776



REPUBLIC OF

PRINCESS MARINA HOSPITAL  
P.O. Box 258  
GABORONE  
BOTSWANA

26 January 2021

Protocol Reference: PMH 2/2A(7)/70

Researcher: Nancy Osupile Potokwane

Study Title: Caring behaviours of Midwives who nurse women during childbirth in Botswana

Application Type: Initial application

Date of Approval: 26 January 2021

Expiration date: 27 January 2022

Permission is granted by the PMH IRB for you to conduct the above study for a duration of one year. You need to note the following:

1. You will not change any aspect of your research without permission from the Princess Marina Hospital IRB.
2. You need to report any unforeseen circumstances including the termination of the study.
3. You must allow Princess Marina Hospital IRB access to the study at any time for purposes of auditing.
4. At the end of the study you should give Princess Marina Hospital IRB a hard copy and soft copy of your report.

Wishing you success in your study

Yours Sincerely

A handwritten signature in black ink, appearing to read 'Joseph Motsumi'.

Mpapho Motsumi  
Chairperson Princess Marina Hospital IRB Committee  
Cell: 00267 72858907  
Work: 00267 3821400  
Email: [josephmotsumi@yahoo.com](mailto:josephmotsumi@yahoo.com)

## Annexure G: Respondents' information document and consent forms




### RESPONDENTS' INFORMATION DOCUMENT

1. Researcher's details	
Title of the research study	<b>Caring behaviours of midwives who nurse women during childbirth in Botswana.</b>
Reference number	H20-HEA-NUR-010
Principal investigator	Nancy Osupile Potokwane
Address	53 Ivana Drive, Summerstrand, Port Elizabeth
Postal Code	6001
Contact telephone number (private numbers not advisable)	+27 73 842 8964/+267 71472568/+267 73929983
2. Declaration by the respondent hereby confirms as follows:	
I, the respondent, was invited to participate in the above-mentioned research study	
That is being undertaken by:	Nancy Osupile Potokwane
from:	Department of Nursing Science
at:	Nelson Mandela University, South Africa.
3. The following aspects have been explained to the respondent:	
3.1	<p><b>Aim:</b></p> <p>The researcher is conducting a study to identify and describe the caring behaviour of midwives who nurse women during childbirth in Botswana, the findings will assist the researcher in making recommendations for midwives and unit managers that could be</p>

		used to optimise the caring behaviour of midwives.
3.2	<b>Procedures:</b>	Your participation in this study is completely voluntary. Giving consent to participate is an indication to the researcher that you agree to take part in the research study, but you may withdraw from the study at any time without penalty if you feel uncomfortable. You will be interviewed using a structured questionnaire to identify and describe the caring behaviours of midwives who nurse women during childbirth in Botswana. The questionnaire will be administered by the researcher and will take approximately 20 to 30 minutes to complete. You will not be required to sign your name on the questionnaire. Your name would only be required on the informed consent form.
3.3	<b>Risks:</b>	You will be free from physical harm or discomfort. There are no foreseeable risks involved in your participation in the study, and you are advised not to answer questions that you feel uncomfortable with. In addition, all information obtained will completely remain anonymous.
3.4	<b>Possible benefits:</b>	This research is not designed for personal benefit, but the results of your participation may assist the researcher in making recommendations for midwives and unit managers that could be used to optimise the

		caring behaviour of midwives when nursing women during childbirth. I hope that, in the future, other people might benefit from the study results that could be used to optimise the caring behaviour of midwives during childbirth.
3.5	<b>Confidentiality</b>	Your personal information will remain anonymous and confidential; you will not be allowed to sign your name on the questionnaire for confidentiality. The questionnaire will bear only number identifiers, and you will be allowed to submit it in a sealed envelope. Your consent form will be submitted separately in a sealed envelope and will be kept in a locked cabinet. Furthermore, your identity will not be revealed in any report, discussion, description or scientific publications.
3.6	<b>Access to findings:</b>	After the completion of the study, a copy of the research results will be submitted to the Ministry of Health and Wellness and the Health Research and Development Division. Moreover, feedback sessions will be arranged with respondents and unit managers in the form of in-service lectures, training or workshops.
3.7	<b>Voluntary participation, refusal and discontinuation</b>	Your participation is completely voluntary. You may choose not to take part at all. If you decide not to participate in this study or if you stop participating at any time, you will not be penalised. Your decision whether or not to

		participate will in no way affect your present or future care, work employment or lifestyle.
--	--	--

4. The information above was explained to me (the respondent), by the researcher	
<p>The information above was explained to me in <b>English</b>, and I understand the language. I was allowed to ask questions, and they were answered satisfactorily. No pressure was enforced to make me consent to participate in the study. I understand that my participation is completely voluntary, and I may withdraw from the study at any time when I feel uncomfortable without giving a reason. Moreover, I will not be penalised and my withdrawal will not negatively affect me in any way. My participation in this study will not result in any additional cost. I am aware that my identity will not be disclosed, my signed consent letter will not be linked with any information obtained and will remain completely anonymous and confidential.</p>	
5. A statement by the investigator	
<p>I, <i>Nancy Osupile Potokwane</i> declare that I have explained the information given in this document to the respondent (see signature below).</p> <p>The respondent was encouraged and given ample time to ask me questions. The conversation was conducted in <b>English</b>, and no translator was required since the respondent is fluent in English language/speaking.</p>	
Signed /confirmed by researcher	Name: Nancy Osupile Potokwane Signature:  Date:
Witness/ respondent full name	Name:
	Signature:
	Date:

**CONSENT LETTER FOR RESPONDENTS AT**  
**THE KGATLENG REGIONAL HEALTH MANAGEMENT TEAM**



**INFORMED CONSENT LETTER**

**Title: Caring behaviour of midwives who nurse women during childbirth in Botswana**

I give my consent to participate in the above-mentioned research project and to complete the structured questionnaire. The study aims to identify and describe the caring behaviour of midwives who nurse women during childbirth in Botswana and to determine the inhibiting factors of the caring behaviour of midwives who nurse women during childbirth in Botswana. I have read the information document explaining the purpose of the research project and my role in it and understand the following:

- My participation is voluntary
- I may withdraw from the study at any time when I feel uncomfortable without penalty, and this will not affect me in any way
- All information obtained will remain anonymous and will be treated with the utmost confidentiality
- I am allowed not to write my name on the questionnaire for confidentiality
- My name will not be identifiable or used in any written study reports
- A written copy of the research outcomes will be shared in the form of in-service training or workshops upon completion of the study
- This study obtained the ethical approval reference number (H20-HEA-NUR-010) from the Nelson Mandela University Research Ethics Committee-Human (REC-H), permission to conduct the study from the Health Research and Development Division of the Ministry of Health and Wellness (reference letter no: HPDME 13/18/1) and the Kgatleng Regional Health Management Team (RHMT) (reference letter no: DRM 3/1/28 II)

- I may seek further information concerning the project from the researcher: Nancy Osupile Potokwane:

Cell number: +27 738428964/+267 71472568/+267 73929983

Email: s208022684@mandela.ac.za

I hereby voluntarily consent to participate in the above-mentioned study:
Name and surname:
Signature:
Date:



**CONSENT LETTER FOR RESPONDENTS AT**  
**THE GREATER GABORONE DISTRICT HEALTH MANAGEMENT TEAM**



**INFORMED CONSENT LETTER**

**Title: Caring behaviour of midwives who nurse women during childbirth**  
**in Botswana**

I give my consent to participate in the above-mentioned research project and to complete the structured questionnaire. The study aims to identify and describe the caring behaviour of midwives who nurse women during childbirth in Botswana and to determine the inhibiting factors of the caring behaviour of midwives who nurse women during childbirth in Botswana. I have read the information document explaining the purpose of the research project and my role in it and understand the following:

- My participation is voluntary
- I may withdraw from the study at any time when I feel uncomfortable without penalty, and this will not affect me in any way
- All information obtained will remain anonymous and will be treated with the utmost confidentiality
- I am allowed not to write my name on the questionnaire for confidentiality
- My name will not be identifiable or used in any written study reports
- A written copy of the research outcomes will be shared in the form of in-service training or workshops upon completion of the study
- This study obtained the ethical approval reference number (H20-HEA-NUR-010) from the Nelson Mandela University Research Ethics Committee-Human (REC-H), permission to conduct the study from the Health Research and Development Division of the Ministry of Health and Wellness (reference letter no: HPDME 13/18/1) and the Kgatleng Regional Health Management Team (RHMT) (reference letter no: DRM 3/1/28 II)

- I may seek further information concerning the project from the researcher: Nancy Osupile Potokwane:

Cell number: +27 738428964/+267 71472568/+267 73929983

Email: s208022684@mandela.ac.za

I hereby voluntarily consent to participate in the above-mentioned study:
Name and surname:
Signature:
Date:

**CONSENT LETTER FOR RESPONDENTS AT**  
**PRINCESS MARINA HOSPITAL**



**INFORMED CONSENT LETTER**

**Title: Caring behaviour of midwives who nurse women during childbirth**  
**in Botswana**

I give my consent to participate in the above-mentioned research project and to complete the structured questionnaire. The study aims to identify and describe the caring behaviour of midwives who nurse women during childbirth in Botswana and to determine the inhibiting factors of the caring behaviour of midwives who nurse women during childbirth in Botswana. I have read the information document explaining the purpose of the research project and my role in it and understand the following:

- My participation is voluntary
- I may withdraw from the study at any time when I feel uncomfortable without penalty, and this will not affect me in any way
- All information obtained will remain anonymous and will be treated with the utmost confidentiality
- I am allowed not to write my name on the questionnaire for confidentiality
- My name will not be identifiable or used in any written study reports
- A written copy of the research outcomes will be shared in the form of in-service training or workshops upon completion of the study
- This study obtained the ethical approval reference number (H20-HEA-NUR-010) from the Nelson Mandela University Research Ethics Committee-Human (REC-H), permission to conduct the study from the Health Research and Development Division of the Ministry of Health and Wellness (reference letter no: HPDME 13/18/1) and the Kgatleng Regional Health Management Team (RHMT) (reference letter no: DRM 3/1/28 II)

- I may seek further information concerning the project from the researcher: Nancy Osupile Potokwane:

Cell number: +27 738428964/+267 71472568/+267 73929983

Email: s208022684@mandela.ac.za

I hereby voluntarily consent to participate in the above-mentioned study:
Name and surname:
Signature:
Date:

## Annexure H: Questionnaire



Dear respondent

Thank you for sparing time agreeing to complete the questionnaire for the study titled: ***Caring behaviours of midwives who nurse women during childbirth in Botswana.***

Your participation and information gathered will be of great value and useful, and your responses will be treated with the utmost confidentiality. You are being asked not to identify yourself or any other person or institution in your responses. Your participation is voluntary and therefore you are asked not to discuss your response to the request and contents of the questionnaire with anyone. Please complete the questionnaire as honestly as possible and indicate your choice by an X.

### **SECTION A: Demographic profile**

#### 1. Age in years

20– 29yrs	
30– 39yrs	
40– 49yrs	
50– 59yrs	
60 or more	

#### 2. Gender

Male	
Female	

3. Level of education

Diploma	
Bachelor's degree	
Honour's degree	
Master's degree	
Other	

4. Years of work experience as a midwife

< 1 year	
1-5 years	
6-10 years	
11-15 years	
16 or more years	

5. Years of work experience as a midwife in this ward/unit

<1 year	
1-2 years	
3-4years	
5 or more years	

6. Your work location

Referral hospital	
District hospital	
Clinic	

7. Do you enjoy working in this maternity ward/unit?

Yes	
No	

**SECTION B: Identifying the caring behaviour of midwives.**

The following statements indicate the aspects of midwifery practice to be caring. Responses are measured according to a 5-point Likert scale from 1 (strongly disagree) to 5 (strongly agree).

Indicate the extent to which you agree or disagree with the statements below. Mark your response with an X:	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. Getting to know the woman					
2. Listening attentively to the woman when communicating					
3. Exploring woman's needs					
4. Obtaining consent					
5. Being honest with the woman					
6. Ensuring confidentiality at all times					
7. Giving clear instructions					
8. Being authentically present during childbirth					
9. Putting the needs of the woman first					
10. Keeping the woman informed about her progress					
11. Giving reassurance about the childbirth process.					
12. Arranging for the woman to see her relatives.					
13. Providing privacy for the woman					
14. Respecting the woman's preferences					
15. Sharing responsibility with the woman					

16. Keeping relatives informed about the woman					
17. Showing genuine interest					
18. Staying at work to complete the job after the shift has ended					
19. Showing professional intimacy					
20. Creating calm atmosphere					
21. Attending to the woman's demanding needs					

**SECTION C: Determine the inhibiting factors of midwives' caring behaviour during childbirth**

The following statements indicate inhibiting factors of the midwives' caring behaviour Responses are measured according to a 5-point Likert scale from 1 (strongly disagree) to 5 (strongly agree).

Indicate the extent to which you agree or disagree with the statements below. Mark your response with an X:	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. Shortage of staff					
2. Work overload					
3. Poor team-working					
4. Absenteeism					
5. Poor collaboration with colleagues					
6. Poor work environment					
7. Language barrier between the midwife and the woman					
8. Lack of verbal appreciation of work done by supervisors					



9. Inconsistent selection of staff for professional development					
10. Lack of equipment					
11. Lack of transport					
12. Inconsistent use of protocols					
13. Demanding attitude of the woman					
14. Woman with no education					
15. Woman with some education					
16. Younger age of the woman (<15 years)					
17. Older age of the woman (30 years and above)					
18. Marital status of the woman (single)					
19. Marital status of the woman (married, cohabitating)					
20. Parity of the woman (first childbirth)					
21. Parity of the woman (more than one childbirth)					
22. Negative attitude of the woman					

**Thank you in advance for your cooperation and understanding**

## Annexure I: Editor's declaration



DR MAUREEN LILIAN KLOS  
PROFESSIONAL EDITOR  
BA; STD; BEd (*cum laude*); MEd (*cum laude*); DEd  
Registered with the SAPEG (reg. no. KLO004)  
maureenklos@gmail.com

---

### EDITOR'S DECLARATION

I,

DR MAUREEN LILIAN KLOS,

Being the holder of the following qualifications:

BA; STD; BEd (*cum laude*); MEd (*cum laude*); DEd

Hereby certify that I am the English language editor of the following document:

CARING BEHAVIOURS OF MIDWIVES WHO NURSE WOMEN DURING  
CHILDBIRTH IN BOTSWANA

by

Nancy Osupile Potokwane

208022684

I hereby certify that I have edited the language, formatting and referencing in the above-mentioned document in their entirety. However, I am not responsible for any changes made to the document after it has been edited.

5 August 2022



## **Annexure K: Turnitin report**

### Turnitin Originality Report

- Processed on: 10-Aug-2022 09:01 SAST
- ID: 1878712981
- Word Count: 29744
- Submitted: 2

Masters Research by Nancy Osupile Potokwane



Similarity Index  
13%

#### **Similarity by Source**

Internet Sources:

11%

Publications:

5%

Student Papers:

3%

Annexure L: Permission to submit dissertation



**PERMISSION TO SUBMIT FINAL COPIES**  
**OF TREATISE/DISSERTATION/THESIS TO THE EXAMINATION OFFICE**

***Please type or complete in black ink***

**FACULTY:** HEALTH SCIENCES

**SCHOOL/DEPARTMENT:** NURSING

I, (surname and initials of supervisor) Smith L. (Dr)

and (surname and initials of co-supervisor) Adams B. (Mrs)

the supervisor and co-supervisor respectively for (surname and initials of candidate) Potokwane NO

(student number) 208022684 a candidate for the (full description of qualification)

Master of Nursing (Research)

---

with a treatise/**dissertation**/thesis entitled (full title of treatise/**dissertation**/thesis):

CARING BEHAVIOURS OF MIDWIVES WHO NURSE WOMEN DURING CHILDBIRTH IN BOTSWANA

---

It is hereby certified that the proposed amendments to the treatise/dissertation/thesis have been effected and that **permission is granted to the candidate to submit** the final bound copies of his/her treatise/dissertation/thesis to the examination office.

*Smith*

11 November 2022

---

**SUPERVISOR**

---

**DATE**

***And***

A handwritten signature in black ink, appearing to be 'Adams'.

11 November 2022

---

**CO-SUPERVISOR**

---

**DATE**