ORIGINAL RESEARCH ARTICLE

The stress of the midwife: Experiences of advanced midwives working in obstetric emergency units in Johannesburg, South Africa

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Abstract

Obstetric emergencies account for the majority of causes of maternal deaths. The major causes of maternal and neonatal deaths in obstetric emergencies include bleeding, pregnancy-induced hypertension, cord prolapse, shoulder dystocia, poor progress, placenta abruptio, placenta praevia and amniotic fluid embolism. These adverse labour and birth events cause emergency situations and trauma for the nursing staff involved. A qualitative, descriptive phenomenological research design was used to explore and describe the lived experiences of advanced midwives regarding the management of obstetric emergencies in Midwife Obstetric Units (MOUs) of Gauteng Province, South Africa. An interview guide was prepared with a major question which was followed by probing questions based on the participant's responses. Semi-structured, face-to-face individual interviews were used to collect data from thirteen (13) advanced midwives who were purposively selected and had been working in the Midwife Obstetric Units for two years or more after obtaining their qualifications. The Midwife Obstetric Units were selected based on the records of their birth statistics. The seven Collaizi's procedural steps were utilised for data analysis. Measures to ensure the trustworthiness of the study were observed within the naturalistic paradigm comprising criteria of credibility; transferability; dependability; and confirmability. Three themes with sub-themes emerged from the current study, namely: psychosocial stress; advanced midwives' workload; and lack of professionalism. In conclusion**,** it was evident that advanced midwives experience psychosocial stress because of unconducive working environments which are not adequately resourced, and high expectations from patients and their families. Management should support advanced midwives with the necessary resources that will enable them to perform their duties effectively and minimise their levels of stress and trauma. *(Afr J Reprod Health 2021; 25[5]: 93-104).*

Keywords: Advanced midwives, lived experiences, midwife obstetric unit, obstetric emergencies, South Africa, stress

Résumé

Les urgences obstétricales représentent la majorité des causes de décès maternels. Les principales causes de décès maternels et néonatals dans les urgences obstétricales comprennent les saignements, l'hypertension induite par la grossesse, le prolapsus du cordon, la dystocie des épaules, la mauvaise progression, le décollement placentaire, le placenta praevia et l'embolie amniotique. Ces événements indésirables liés au travail et à l'accouchement provoquent des situations d'urgence et des traumatismes pour le personnel infirmier concerné. Une conception de recherche phénoménologique qualitative et descriptive a été utilisée pour explorer et décrire les expériences vécues par des sages-femmes avancées concernant la gestion des urgences obstétricales dans les unités obstétricales de sages-femmes (MOU) de la province de Gauteng, en Afrique du Sud. Un guide d'entretien a été préparé avec une question principale suivie de questions d'approfondissement basées sur les réponses des participants. Des entretiens individuels semi-structurés en face-à-face ont été utilisés pour collecter des données auprès de treize (13) sages-femmes avancées qui ont été sélectionnées à dessein et qui travaillaient dans les unités d'obstétrique des sages-femmes depuis deux ans ou plus après avoir obtenu leurs qualifications. Les unités d'obstétrique des sages-femmes ont été sélectionnées sur la base des dossiers de leurs statistiques de naissance. Les sept étapes procédurales de Collaizi ont été utilisées pour l'analyse des données. Des mesures pour assurer la fiabilité de l'étude ont été observées dans le paradigme naturaliste comprenant des critères de crédibilité ; transférabilité; fiabilité; et la confirmabilité. Trois thèmes avec des sous-thèmes ont émergé de la présente étude, à savoir : le stress psychosocial; charge de travail avancée des sages-femmes ; et manque de professionnalisme. En conclusion, il était évident que les sages-femmes avancées subissent un stress psychosocial en raison d'environnements de travail peu propices qui ne disposent pas de ressources suffisantes et des attentes élevées des patients et de leurs familles. La direction doit soutenir les sages-femmes avancées avec les ressources nécessaires qui leur permettront de s'acquitter efficacement de leurs tâches et de minimiser leurs niveaux de stress et de traumatisme. *(Afr J Reprod Health 2021; 25[5]: 93-104).*

Mots-clés: Sages-femmes avancées, expériences vécues, unité d'obstétrique sage-femme, urgences obstétricales, Afrique du Sud, stress

Introduction

Obstetric emergencies, which threaten the well-being of the woman and the unborn child, account for the majority of causes of maternal death. Obstetric emergencies are sudden, unexpected, life-threatening medical conditions that occur during pregnancy, labour, delivery or puerperium[1.] The World Health Organization (WHO) has listed the following conditions as obstetric emergencies: ectopic pregnancy; placenta abruptio; placenta praevia; pregnancy-induced hypertension; premature rupture of membranes; amniotic fluid embolism; placenta accreta; cord prolapse; shoulder dystocia; postpartum haemorrhage; and postpartal infections[2,3.] This list is supported by Abdelhakm[4] whose findings state that the major causes of maternal death include haemorrhage; infections; unsafe, induced abortion; hypertensive pregnancy disorders; and obstructed labour.

Common indications for obstetric emergency referrals include preterm labour (30,6%); pregnancy-induced hypertension (17%); fetal distress (10.6%); previous caesarean section (10%); malpresentation (8.5%); and poor progress (8%)[5.] Soma-Pillay[6] asserts that patients suffering from acute, life-threatening conditions such as obstetric haemorrhage (13.2%), pregnancy-induced hypertension (15.4%) and infections (2%) were referred to tertiary institutions by advanced midwives for further management. As indicated by Levin[7] in one of the midwife obstetric units (MOUs) in the Johannesburg region of South Africa, the indications for emergency obstetric referrals to tertiary institutions were pregnancy-induced hypertension (22.8%), poor progress (16.8%), foetal distress (14.7%), antepartum haemorrhage (2.4%) and postpartum haemorrhage (13.6%). As indicated by Spiegelman[8] post-partum haemorrhage (PPH) was the most common cause of maternal mortality in the United States (11,4%), and occurred most frequently between 2011 and 2013. These findings are not so different from the South African's National Committee on Confidential Enquiry into Maternal Death (NCCEMD) in the Saving Mothers report of 2014-2016 which indicated that obstetric haemorrhage was the third most common cause of maternal deaths.

In the Saving Mothers report of 2011-2013, the committee recommended that health care facilities should be appropriately resourced in terms of both human and material resources[9,10]. Despite this recommendation, advanced midwives still find themselves working in health care facilities and MOUs where they have to function without doctors and which are not adequately resourced. They are expected to work without basic resources such as catheters, drip sets, suturing materials and delivery packs that would enable them to manage obstetric emergencies. In Ghana the antenatal clinics were found to be operating with shortages of basic equipment such as syringes, gauze swabs and gloves, essential for their daily routine[11.]

As indicated by Wahlberg[12] midwives are traumatised and have to deal with regaining their self-image after experiencing an obstetric emergency where a death of either the neonate or the mother has occurred. The midwives' reactions mostly depend on the woman's reaction after the negative event and the fear of the verdict that will follow. Midwives who participated in obstetric emergencies reacted with anxiety and panic when the woman's physical condition deteriorated. Midwives also felt guilty and blamed themselves when the birth of a neonate in an emergency led to the loss of life. They also experienced sadness and compassion if the obstetric emergency led to the death of the woman and they had to explain the situation to the family[13]. Midwives who witnessed or were involved in an obstetric emergency described it as chaotic and urgent, producing feelings of shock, fear, horror and apprehension[14]. During a stressful situation such as this, midwives expressed that they felt powerless and were unable to advocate for the woman, more especially when they felt that the interventions and/or equipment were inadequate[14]. This motivated the researcher to conduct this study in order to explore and describe the lived experiences of advanced midwives working and managing obstetric emergencies in selected MUOs of Gauteng Province, South Africa and to propose ways of minimising the stress they suffer.

Methods

Qualitative, explorative and descriptive phenomenological research was used to obtain

information from the participants. Little is known about the lived experiences of advanced midwives regarding the management of obstetric emergencies, so to determine the nature of the problem, an explorative descriptive phenomenology was deemed to be appropriate for this study. The qualitative approach allowed the researcher to explore the information that the participants provided more fully, giving greater insight into how the participants experienced and reacted to emergencies.

Setting

The study was conducted in Johannesburg, Gauteng Province, South Africa. Johannesburg consists of seven health districts ranging from region A to G. For the purpose of this study, the researcher chose MOUs from Region D which encompasses the whole of Soweto and is located in the south west of Johannesburg, bordering the city's mining belt on the south. Region D contains six MOUs, namely: Lillian Ngoyi; Chiawelo; Mofolo; Itereleng; Zola; and Lenasia South. All six of these MOUs were selected by the researcher for the purpose of data collection because in these health districts the advanced midwives work independently to manage obstetric women, including obstetric emergencies.

A midwife obstetric unit is a primary level care facility for pregnant women which is managed by advanced midwives and midwives, and is located within the primary health care system[15]. The MOUs operate twenty-four (24) hours every day and in most shifts there is an advanced midwife who is assigned as a shift leader and two other midwives with only basic midwifery training and one auxiliary or enrolled nurse under her supervision. The MOU comprises an admission room, labour room, delivery room and a postnatal room. The National Department of Health has laid down the services that should be offered in the MOU: low to intermediate risk antenatal care; management of obstetric emergencies; comprehensive contraceptive care; and referral of problems to hospitals[15].

Population

In this study the population constituted advanced midwives who had been working in the MOUs for two years and more after obtaining their qualifications as advanced midwives. Each MOU had five to eight (5-8) advanced midwives, with a total of thirty-three (33) for all the MOUs, twenty-eight (28) of whom met the inclusion criteria. The researcher interviewed those advanced midwives that happened to be on duty on the particular days when the MOUs were visited, as long as the participants fitted the inclusion criteria (outlined below) and volunteered to participate in the study.

Sampling

The researcher used convenience, non-probability sampling to obtain data from the participants, but only those advanced midwives who volunteered to participate and had worked in the MOUs for more than two years after obtaining their advanced midwifery qualification were interviewed. The researcher first visited the six MOUs and interviewed one participant in each, followed by randomly selecting the MOUs based on the availability of participants. Data saturation was reached after the researcher had interviewed twelve (12) participants, but the researcher went back to the MOUs where one participant was interviewed to confirm data saturation.

Although the researcher interviewed the accessible population, sampling bias was partially avoided because advanced midwives from various MOUs in Johannesburg District D were interviewed. This meant that the accessible population was heterogeneous in its characteristics.

Data collection

Semi-structured individual interviews were used to collect data from the participants. An interview guide with a broad, open-ended question was constructed as follows:

> *Can you tell me about your experiences as an advanced midwife working in a Midwife Obstetric Unit*?

Follow-up questions were asked based on the participants' responses to encourage the participants to clarify and develop some of the information that they had provided, so that the researcher could gain an in-depth understanding of

the information that was provided. Interviews were recorded using an audio recorder with the permission of the participants, in order to capture the respondents' information properly and then transcribe it for the purpose of data analysis. While conducting the interviews, field notes were taken and the participants' behaviours were observed and recorded. In the field notes the researcher recorded the conversations, behaviours, personal experiences and feelings expressed during the interviews. Data were collected from the 21st of September to 06th of October 2019 through individual interviews which each lasted for thirty (30) to forty-five (45) minutes.

Data analysis

Data were analysed using Colaizzi's (1978) seven procedural steps. Colaizzi's process was suitable for this research because it enabled new knowledge to be revealed and provided insight into the phenomenon under study, thus ensuring the credibility and reliability of the results. In phenomenology, data analysis goes hand-in-hand with data collection, and the aim is to respect and retain the originality of the participants' lived experiences while the researcher is giving proper attention to the phenomenon under investigation. The researcher first listened to the audio-recorded interviews and transcribed them verbatim. She then compared the transcribed information with the field notes so that non-verbal expressions could be added to the transcribed information. The researcher then listened to the audio-recorded interviews to verify if the transcripts were accurate and to make corrections where necessary.

Each transcript was reviewed and important statements were extracted and marked using coloured pens. The colours and the meanings given to them were written on the field notes to ensure that the meanings were matched with the correct colours. This helped the researcher to organise, identify, retrieve and analyse the data accurately. The researcher gave meanings to the formulated grouped statements according to their colours, which were then linked with the collected data in order to make sure that each statement was correctly categorised. The formulated meanings were organised into a cluster of themes. The researcher examined the clustered meanings and grouped those categories that reflected the lived experiences of advanced midwives regarding the management of obstetric emergencies in the MOUs. With the help of the supervisors, the researcher studied the clustered themes and formulated comprehensive descriptive meanings of the lived experiences of advanced midwives regarding the management of obstetric emergencies. The findings of the study were integrated into an exhaustive description of the phenomenon that was being investigated. Finally the researcher went to the participants and gave them the transcripts for them to verify if the descriptions given to the statements matched their lived experience as advanced midwives managing obstetric emergencies.

Trustworthiness of the study

The trustworthiness of this research was observed within the naturalistic paradigm of Guba and Lincoln (1985) which entails the criteria of credibility, transferability, dependability and confirmability.

Credibility

As a means of ensuring credibility, the researcher collected data from six MOUs. A heterogeneous sample based on age and experience was interviewed. Triangulation was achieved by using various strategies to collect the data. The researcher conducted semi-structured individual interviews where the participants were allowed enough time to share their lived experiences. Follow-up and probing questions were asked so that the participants could clarify and enlarge on the information that they had provided. An audio-recorder was used to record the conversation and verbatim transcripts were made to ensure that the information was an accurate reflection of the direct statements from the participants. The researcher also kept field notes which included any non-verbal gestures observed.

Transferability

A thick description of the research design, methods and data discussion was provided in order to ensure that if another researcher wanted to use methods, participants and a setting different from but similar to those used by the researchers of this study, they

had access to the methods used. To ensure the transferability of the findings, the researcher interviewed advanced midwives who had been working in the MOUs for more than two years and the interviews continued until data saturation was reached. Interviews were audio-recoded to make sure that the results were dependable.

Dependability

To safeguard dependability, the researcher ensured that the selected advanced midwives in this study remained the only population, as they were the participants who were in the best position to provide answers to the research question. The researcher consulted with the supervisors to reach consensus on the emerged themes.

Confirmability

To ensure confirmability, all interviews were audio-recorded and copies were given to supervisors who then confirmed that the information accurately represented the participants' verbal information. A literature control of all identified themes was carried out and the findings were aligned with the data throughout to ensure that the interpretation truly represented the advanced midwives' lived experiences regarding the management of obstetric emergencies in the MOUs.

Results

Participants' biographic profile

Data was gathered from thirteen (13) advanced midwives who had two years' experience or more. The advanced midwives with the least experience had three (3) years' post-advanced midwifery training and the most experienced had thirteen (13) years. Their ages ranged from thirty-four (34) to sixty-four (64) years. All the participants in this study were females.
Three themes with six sub-themes emerged, as depicted in Table 1.

Theme 1: Psychosocial stress

Most participants indicated that despite the challenges posed by their working environments, the patients and their families came with expectations which in most cases went beyond what advanced midwives are required to do. The advanced midwife was often faced with the challenge of fulfilling their institutional obligations on the one hand and on the other trying to satisfy the patients and their families. Most of the time, participants indicated that they felt demoralised by their work situations. This is what some of the participants had to say:

> *"Human and materials resource are a big problem, shortage of staff affects the management of obstetric emergencies being alone, the patients can even die because if you shout for help you are calling an enrolled nursing assistant, and who does not know what to do. This is what makes an advanced midwife to be always emotionally depressed because you cannot work alone. On the other hand, the relatives of the woman you are assisting will expect you do to miracles especially if the woman is not progressing well."* **(Participant 8)**

Another participant added:

> "*Those are the things that makes you demoralized". "I am trying to work myself out of that situation of being demoralized because of my experiences at the MOU". "I am demoralized by the patients, they don't appreciate. You do anything and everything, they don't appreciate."* **(Participant 10)**

Two sub-themes emerged from this theme, namely; stress due to the unconducive working environment and high expectations from patients and their families.

Sub-theme 1.1: Stress due to unconducive working environment related to lack of resources

The situations in which advanced midwives find themselves working, for example, where they have to work with staff shortages, insufficient equipment and a shortage of ambulances that should assist them in performing their duties, expose them to various degrees of psychosocial stress. The two factors are compounded by the fact that despite

Table 1: Experiences of advanced midwives in managing obstetric emergencies (n=13)

Theme	Sub-themes
Psychosocial stress	Stress due to an unconducive working environment related to lack of resources High expectations from patients and their families
Advanced midwives' workload outlined	Advanced midwives as team leaders
	Advanced midwives as teachers
	Advanced midwives as consultants
Lack of professionalism experienced	Unruly, deviant behaviours displayed by midwives and other junior nurses

difficult circumstances they receive no support from the management; instead they are just left to cope and survive as best they can. During the management of obstetric emergencies the outcome mostly depends on the availability of resources, and if these are not available, the outcome might be negative, for example, either the baby or the mother dies, and this further adds to the stress of the advanced midwives. One participant said:

> "*Shortage of equipment and staff makes rendering quality care impossible, and you are this person who want to render quality service. But because I don't have things that will make me to achieve my goal, rendering quality service becomes impossible.*" **(Participant 10)**

Another participant added:

> "*Sometimes when you want to come to work, eish, you become frustrated and say, I am going to that place, there is nothing to work with, the staff is not enough and there is lack of support from the managers because most MOUs does not have managers.*" **(Participant 12)**

One participant who explained how other midwives felt after the mother had just delivered a still-born neonate put it this way:

> *"Emotionally they were not okay after that, more especially because the baby was okay throughout and they were expecting a live baby. This situations frustrate us, sometimes one need support from the manager but there is no support."* (**Participant 6**)

Some of the participants indicated a shortage of ambulances as one of the factors that hindered their patients' care. As one participant commented:

> *"Problem with the management of obstetric emergencies is when you call the ambulance when there is a problem, and the ambulance is delayed. We have to in the meantime manage the patient, we can't leave the patient.*" (**Participant 2**)

Another participant clearly indicated the amount of time she had waited for an ambulance:

> *"The longest time I have waited for an ambulance is ±3 hours. When we phoned for the ambulance control office, we were told that the ambulance is busy with casualty patients."* (**Participant 12)**

Sub-theme 1.2: High expectations from patients and their families

Participants in this study explained that in their daily activities they were faced with patients and their families who expected them to manage patients in a specific manner. The patients' and families' expectations sometimes ran counter to the way the health system operates. This challenge became worse if the patient outcome was not good because families tended to assume that advanced midwives had neglected the patients. Participants narrated their experiences as follows:

> "*The most challenging experience is when the patient's family want you to do something that according to how they want it to be done other than what you are supposed to do. Some family members would tell you not to cut an episiotomy even when is indicated, and the woman ends up with a third-degree tear which is difficult to suture.*" **(Participant 1)**

Another participant had this to say about the way relatives put blame on them for negative outcomes:

> "*When it happens that the baby died because of various reasons, the family will ask you, why you did not do this and that, why did you not refer her to hospital if you are failing, even if when they came, there was no heartbeat and the woman was fully dilated.*" **(Participant 12)**

Another participant commented:

> *"The attitude of our patients, mostly make our work difficult. Even their families because sometimes they will like you to do things their own way."* (**Participant 11**)

Theme 2: Advanced midwives' workload outlined

Participants reported that, apart from performing patient-care duties, they were expected to perform teaching and leadership functions and act as role models as they were consultants for the midwives working with them. They did not view their workload as a problem since this was outlined in their scope of practice from South African Nursing Council, but it became one when there was a shortage of staff. This view was supported as follows:

> *"Hmmm…working in the MOUs has its own advantage and disadvantage. You become a consultant for your junior nurses as they see you as an expert in everything. The problem occurs as most of the time, you will find that we are understaff. You are to lead and show them how to assess and manage the woman in labour." (***Participant 4)**

Three sub-themes emerged from this theme relating to the workload of the advanced midwives, namely: advanced midwives as team leaders; advanced midwives as teachers; advanced midwives as consultants.

Sub-theme 2.1: Advanced midwives as team leaders

The participants in this study narrated that after their training as advanced midwives, they were given the roles of leading the teams that they are working with. As team leaders they were expected to take responsibility for what was happening in that particular team. The complete team was one advanced midwife, two midwives and an enrolled nursing assistant. The advanced midwife needs to make sure that the other people that she is allocated to work with, perform their duties as expected. Concerning this role, one participant observed:

> *"It means to be functioning independently, because at MOU we don't have the doctor, so MOU the midwife runs the institution, so it means that you have to be hands on. Whatever comes, whatever challenge that comes, the first person they call is an advanced midwife."* (**Participant 2**)

Another participant said:

> *"To me to be an advanced midwife it meant that taking responsibilities and leading by being exemplary and doing my best, everything that I could do and for my patient, to my level best."* (**Participant 10**)

Another participant added:

> *"For me it means you are taking responsibility of managing your subordinates, because usually when you are an advanced midwife you have a role of being a group leader."* (**Participant 3**)

Sub-theme 2.2: Advanced midwives as teachers

Participants indicated that one of their responsibilities as clinical midwife specialists was to make sure that the staff members that they were working with were able to perform optimally in order to render patient care that would lead to patient satisfaction. The advanced midwives achieved this by teaching their subordinates and the allocated students in the MOUs. One participant explains this:

> *"Like the staff that we are working with, as a team leader you teach them so that when there is an emergency they know what to do."* (**Participant 1**)

Another participant said:

> *"You are a student teacher. That one 'ke e bona e le nicer' (I see it as good) because, now I am somebody who can teach people."* (**Participant 8**)

Yet another participant added:

> *"You take responsibility of everything, you work independently, you must be able to teach the students and your juniors."* (**Participant 12**)

Sub-theme 2.3: Advanced midwives as consultants

Though in South Africa we do not have a separate scope of practice for midwives and advanced midwives, the advanced midwifery training enables the advanced midwife to perform certain functions that a midwife with basic training cannot perform. Thus when the basic midwives encounter a problem in the MOUs, they refer to the advanced midwife who will then assess and plan the care of the patient. One participant described her consultancy role like this:

> *"When the subordinates examine the woman, they refer the same woman to you for confirmation of their findings."* (**Participant 4)**

Another participant added:

> *"When there are problems in the unit, they are always looking for you, even the experienced midwives, they are relying totally on you.*" (**Participant 9**)

Theme 3: Lack of professionalism

Advanced midwives sometimes find themselves working with midwives who lack a sense of responsibility; who can just decide not to come on duty even if they know that their absence would mean that the team will be understaffed. Such midwives display a lack of professionalism. This was said to happen following correction of midwives by an advanced midwife. This is what one participant said:

> "*You know this people, you can advise them on anything and they don't take any correction easy, for example, if someone takes a long tea-break, you call and reprimand her, you know that the following day or days this person will be absent. You just keep quite even if things are wrong because you will be left alone*" **(Participant 1)**

Sub-theme 3.1: Unruly, deviant behaviours displayed by midwives

Participants indicated that, as they were the ones with specialist training and most of the time were leading the unit, when they noticed that midwives and other nurses were not doing their work correctly, they tried to correct them through teaching and this caused an angry reaction. The nurses did not view the corrections as empowerment but as a punishment, and became unmanageable.

> *As a leader, an advanced midwife, sometimes when you try to teach people, you show her you must do this and this, others get angry. You know nowadays people, a touch is a move."* (**Participant 1**)

The participant further added that although they sometimes complained of a shortage of staff, some of the midwives were absent from work purposely.

> *"When it comes to shortage, sometimes is not shortage per se, like when you are trying to reprimand, they will be falling off sick all of them, you will be left alone."* (**Participant 1**)

Another participant had this to say about the slackness of certain staff members:

"And another thing is staff who don't have the sense of urgency, those who don't see that this is an urgent thing, they take their time. Not that they don't know what to do, but they don't have a sense of emergency, they don't see things the way you want them to see." (**Participant 2**).

Discussion

Psychosocial stress

Advanced midwives in this study expressed various reasons for the psychosocial stress they suffered in

their working situations. Some of the stressors were caused by the shortage of both human and material resources, delays of ambulances and lack of support from management. This had a negative impact on the management of women in labour and led to negative outcomes. This is illustrated by the results indicated by Ramavhoya's study[3] where there was a lack of support from other midwives and managers at the primary health care facilities, caused by a shortage of staff. The authors discovered that, most of the time, pregnant women were assisted by one midwife instead of two during both day and night[3,16,17]. Another study which endorsed the findings of the current study was conducted in Tanzania, where the health system provision for pregnant women is the same as in South Africa. There the midwives lacked basic equipment needed to enable them to perform their daily activities[18]. The authors further indicated that lack of equipment exposed midwives and their patients to danger, and maternal health care was compromised. In addition to psychological stress caused by unconducive working environments, the results of the current study revealed that advanced midwives were expected to perform miracles by the relatives of women who came for delivery. In cases of complicated delivery, advanced midwives used their knowledge, skills and experience gained throughout their years of training but sometimes unexpected problems arose, and family members expected them to save the situation. Advanced midwives expressed feelings of frustration, irritation and guilt as a result of some of the situations they came across. All these stressors were aggravated by negative outcomes in the management of the obstetric emergencies, such as the death of either the woman or the neonate. Advanced midwives felt that they had failed because the equipment used was inadequate or inappropriate, but then were pressurised and blamed by family members. They felt powerless and guilty because they thought they were unable to advocate for the woman or baby.

Similar results to those of the current study emerged from the study conducted by Elmier[14] where midwives' and nurses' experiences of adverse labour and birth events demoralised them especially if there was a death of a neonate or mother. In support of the findings of the current study, midwives who witnessed or were involved in an obstetric emergency were badly affected, resulting in poor management of women in future[16]. A study conducted on Danish midwives indicated higher scores on burnout, sleep disorders and somatic stress following a traumatic childbirth[17]. Midwives experienced emotions ranging from intense fear, panic and helplessness to guilt; and during the moments of exposure to the obstetric emergency they felt their professional role was threatened[18].

Stress from the patients and their families led to feelings of confusion and frustration in the advanced midwives, further impairing their functioning. This in turn weakened the image of the health system at large. Midwives could display negative attitudes to the patients who would then speak badly about the health services rendered. This could encourage the advanced midwives to absent themselves from work and so perpetuate a vicious cycle.

Advanced midwives' workload outlined

The findings of this study revealed that, regardless of their duty to care and the challenges that they were facing on a daily basis, they were also allocated as team leaders who were responsible for the efficient functioning of the MOUs. The advanced midwives' roles include supervision of the junior staff members and other midwives, teaching students, confirming the findings of the other midwives, effectively making them consultants in the MOUs. The findings of this study were in line with the report that was done to evaluate the training of advanced midwives in South Africa where the advanced midwives in all the provinces reported that their duties included teaching junior doctors and other midwives, advocacy for patients by advising on the care, coordinating functions in the MOUs and teaching students[18]. As indicated by Ojuri-King[19] the roles of midwives included supervision of the junior staff members who included students and non-specialist nursing staff.

Although advanced midwives in this study indicated that one of their responsibilities was to teach students, experienced midwives in Limpopo explained that the lack of independence and commitment by newly qualified midwives led to

frustration on the side of the experienced midwives[20]. Midwives had a negative attitude towards students and verbalised their unwillingness to teach as they were not lecturers[21]. Although some studies[22,23] revealed that experienced midwives were not willing to teach new midwives who were allocated to midwifery settings, in this study advanced midwives expressed willingness to teach and help other midwives and students who were lacking in some skills and confidence in the management of obstetric emergencies. This was beneficial for both the institutions; the health service and the patients, because quality care would be rendered and patient satisfaction enhanced.

Lack of professionalism

Participants in this study also revealed that some of the midwives and nurses (enrolled nurses and auxiliary nurses) simply decide to be absent because they were reprimanded or corrected for wrong actions. Some participants indicated that some nurses were absent because it was a holiday and they wanted to be with their families. Staff members who demonstrated such lack of professionalism disadvantaged the patients and aggravated the stress levels of the advanced midwives. This is supported by the study of Mbombi[24] which showed that the increased workload for the remaining staff caused stress leading to medical errors while performing their duties. Contrary to the results of the current study, Matlala[22] found that midwives had a negative attitude towards their junior nurses and verbalised their unwillingness to assist them when rendering maternal health care services. This contributed to their absence in the workplace causing further staff shortages and poor patient care and outcomes.

Ethical considerations

Permission to conduct the research in MOUs in the Johannesburg Region D was granted by the District Ethics Committee after the ethical clearance certificate from the University of Pretoria Faculty of Health Sciences Ethics committee (ethical clearance number 294/2019) was submitted. Participants were interviewed in private rooms and assured that the information would not be divulged to anybody to ensure its confidentiality. Participants were also told that their names and MOUs would not appear in written form anywhere to protect their anonymity. Participants voluntarily signed an informed consent form after a thorough explanation of the purpose of the study. Participants were also made aware that they could freely withdraw from the study if they felt they did not want to continue with it, and there would be no penalty for withdrawal.

Conclusion

Psychosocial stress was identified as resulting from working in an environment that was not favourable due to a shortage of staff and resources. When emergencies arose, advanced midwives struggled to cope and suffered stress which was exacerbated by negative outcomes such as the death of a mother or neonate. This stress was aggravated by patients and family members who had unrealistic expectations of midwives' capabilities and left midwives with feelings of failure and guilt when adverse labour and birth events occurred. The advanced midwives in this study demonstrated professionalism by working as team leaders, teaching their subordinates and working as consultants. Although they felt that they were doing their best to fulfil these duties, their function was often compromised by other midwives who absented themselves from work for no good reason, and by a lack of essential resources.

Recommendations

To improve the quality of care in the MOUs, the following recommendations were made:
The midwifery staffing norm should be adhered to and the MOUs must be allowed to call in part-time staff if the need arose. More midwives from the MOUs should be trained to become advanced midwives. Management should support the advanced midwives with necessary resources that would enable them to perform their duties effectively.
Providing counselling services for midwives needing psychological support after a traumatic experience such as a death of mother or baby. Morale-boosting workshops should be organized

for demoralised nursing staff who missed work because of stress.

Limitations

Although this study provides a rich description of the lived experiences of the advanced midwives working in MOUs in Gauteng Region D and being involved in obstetric emergencies, some limitations should be noted. Since the researcher used convenience sampling, the findings might not represent the lived experiences of all the advanced midwives in the MOUs and in the clinics where midwifery services are rendered, and as such the study findings should be applied with caution. Furthermore, although similar findings have been made by other studies in South Africa, the study findings still need to be applied with caution because the conditions in the province in which the research was conducted might have changed or improved.

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Contributions of authors

I, Kavanyeta Elizabeth Mashamba declare that I have collected and analysed the data with the help of Doctor T.I Ramavhoya. I am the author of this article. With the help of Doctor T.I Ramavhoya, conceived and designed the study and prepared the manuscript. Both of us approved the manuscript.

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