# BIRTHING PROCESS PREPAREDNESS OF FIRST-TIME MOTHERS IN THE PUBLIC OBSTETRIC UNITS OF THE NELSON MANDELA BAY HEALTH DISTRICT (NMBHD).

X. DLAMINI

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# BIRTHING PROCESS PREPAREDNESS OF FIRST-TIME MOTHERS IN THE PUBLIC OBSTETRIC UNITS OF THE NELSON MANDELA BAY HEALTH DISTRICT (NMBHD).

by

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## ABSTRACT

The birthing process is a challenging, unpredictable yet a beautiful life event for birthing women, requiring reasonable birthing process preparedness on birthing woman to enhance her cooperation during the birthing process. Often first-time mothers lack their own frame of reference regarding the birthing process to improve their birthing process preparedness. As an alternative they are reliant on that of other people with birthing process experiences or on what they are told by midwives.

The purpose of this study was to understand how was the preparedness of the birthing process of first-time mothers in the public obstetric units of the NMBHD. Thus, an indication of how ready were they, when the labour started. The objectives of the study were as follows, to:

- explore and describe the birthing process preparedness of first-time mothers in the public obstetric units of the NMBHD and
- formulate recommendations for midwives and nurse managers that would aid them in facilitating the birthing process preparedness of first-time mothers in public obstetric units in the NMBHD.

The study adopted a qualitative research design with exploratory, descriptive and contextual approach. The research population were first-time mothers who had booked and delivered in any of the obstetric units in the NMBHD. The convenience, non-probability sampling methods were used in selecting the first-time mothers who met the inclusion criteria. Envisaged sample size was 21 participants but also depending on data saturation. Sixteen participants were ultimately interviewed but only fifteen of those interviews were used. The data collection method used was one-on-one semi-structured interviews which were captured on a digital voice-recorder. The thematic method of data analysis was used to analyse data from the interviews. Three main themes emerged from the data analysis:

- Theme 1: Participants shared their experiences regarding the birthing process and their birthing process preparedness.
- Theme 2: Participants expressed having had varied experiences from factors that had influenced their birthing preparedness.

- Theme 3: Participants provided suggestions for midwives to facilitate their birthing process preparedness.

Recommendations were made for midwives and managers, nursing education, research and limitations of the study were outlined. To comply with trustworthiness, this study adopted Lincoln and Guba's Model of trustworthiness. The ethical principles that guided this study with human participants were the principles of respect for persons, beneficence, non-maleficence and justice.

**Key words:** Birthing experience, birthing preparedness, birthing process, delivered women and first-time mother.

## LIST OF ABBREVIATIONS

| | |
|---|---|
| ANC | - Antenatal Care |
| BANC | - Basic Antenatal Care |
| DNS | - Department of Nursing Science |
| DoH | - Department of Health |
| FPGSC | - Faculty Postgraduate Studies Committee |
| NMBHD | - Nelson Mandela Bay Health District |
| USA | - United States of America |
| WHO | - World Health Organisation |

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# CHAPTER 1

# OVERVIEW OF THE STUDY

## 1.1 Introduction

The birth of a baby is often associated with joy and excitement by the expectant mother and her family; but occasionally despair and disappointment are inevitable. The above-mentioned emotions could at times emerge from the mother being ill-prepared for her birthing process, especially if the birthing woman is a first-time mother. The birthing process preparation expected in this regard is usually done during the antenatal care period and in the appropriate clinic or a unit offering that necessary service. Those previously mentioned emotions could potentially increase the pressure on the midwife who is attending to the birthing woman. Therefore, compelling the midwife to use interventions which could have been unnecessary if the birthing woman had been better prepared and ready for her birthing process.

This study used a qualitative design with an exploratory, descriptive and contextual approach in order to explore and describe the birthing process preparedness of first-time mothers in public obstetric units of the Nelson Mandela Bay Health District (NMBHD). The results were used to formulate recommendations for midwives and nurse managers that would aid them in facilitating birthing process preparedness of first-time mothers in public obstetric units in the NMBHD.

## 1.2 Background and orientation to the study

Antenatal care (ANC) is the approach which encompasses medical care and procedures that are rendered to pregnant women throughout pregnancy and until the birth of the child (Ngxongo, Sibiya & Gwele, 2016: 1). Such service can be provided either at a hospital, primary healthcare clinic or doctor's rooms. Essentially, ANC focuses on detecting problems which might affect the pregnant woman and/or her unborn baby in a detrimental manner. The purpose of ANC is to monitor the progress of pregnancy which therefore includes the growth of the fetus and screening of other problems that may cause a risk to the pregnancy (Dippenaar & de Serra, 2018: 218).

Monitoring done at ANC clinics is expected to include advice to the women about care during pregnancy and also what to expect during labour and birth (WHO, 2015: 14) which in the context of this study refers to the preparedness for the birthing process. In so doing a midwife assumes that the pregnant woman will be sufficiently prepared for her birthing process and relieved of a major experience of distressing emotions. Such preparation should ideally be evaluated from time to time for its relevance and impact on the birthing woman.

The WHO provides an ideal roadmap of preparation for the birthing process for pregnant women, one of the major indicators of this, being safe motherhood (Adhikari, 2018: paragraph 1) and antenatal care for a positive pregnancy experience (WHO, 2016: xi). The basic antenatal care (BANC) model, which is a global tool supposed to be used in the monitoring of women during the antenatal period, has been adopted by South African National Department of Health (DoH) as a policy adapted to its citizens (DoH, 2016: 13) providing in that manner the required birthing process preparedness.

According to the BANC it was recommended that a pregnant woman should attend an ANC clinic for a minimum of four to five visits for close monitoring (DoH, 2016:38). These minimum visits were meant for low-risk pregnancies and condition of the woman (WHO, 2015: 17). Owing to persistent complications of pregnancy and birth, South Africa has further adopted the BANC plus model which recommends eight antenatal visits (Pattinson, Hlongwane & Vannevel, 2019: 15). While the BANC plus model advocates monitoring of pregnant women more frequently than previously considered necessary, no mention has been made of a specific process or criteria regarding birthing process preparation and expectations for the birthing process for the first-time mothers.

Some known contributors to expectations of birthing outcomes are a woman's level of education, prenatal education programmes, birthing experiences, influence of authority figures and the stories from friends, families and or media (Sengane, 2013: 1). These aspects and perhaps unrealistic expectations can often exacerbate pressure on the attending midwife. Consequently, associated with feelings of negative overall birthing experiences among birthing women when these expectations are not fulfilled (Hildingsson, 2015: 7). Such feelings may be more observable in the first-time mothers as they do not have previous experience of the birthing process.

As a frame of reference regarding their preparedness for the birthing process, first-time mothers may have received the information from informal sources such as families and friends (Leahy-Warren, McCarthy & Corcoran, 2011: 5). Such information, which could mislead the first-time pregnant woman as it may be based on these people's own previous and not fully explained experiences. That information may have a negative influence and pose a threat to birthing process preparedness and the birthing experience desired by first-time mothers. Congruent with this statement, Klomp, Witteveen, de Jonge, Hutton and Lagro-Janssen (2016: 96) attest that story about previous birthing experiences are not always factual and can instead do more damage than good because experiences of the birthing process vary from woman to woman according to Klomp et al. (2016: 96). It is therefore advisable for pregnant women to attend ANC clinics regularly and for midwives to ensure reasonably successful birthing preparation, especially of first-time mothers by accelerating their birthing process knowledge and birthing process readiness. Hassanzadeh, Abbas-Alizadeh, Meedya, Mohammad-Alizadeh-Charandabi and Mighafourvand (2019: 6) are of the opinion that lack of knowledge and unpreparedness can lead to complications and the need perhaps for emergency medical interventions.

In the United States of America (USA), birthing process preparedness is an organised system in the form of childbirth classes which is thought to be best if it begins in the third trimester of pregnancy and continues throughout the remainder of the pregnancy (Abbyad & Robertson, 2011: 46). These classes are also known to take place successfully in Australia as well (Cutajar, Miu, Fleet, Cyna & Steen, 2020: 1) and are considered to empower and enhance a birthing woman's childbirth experience (Hassanzadeh et al., 2019:1). In another context, in a study done in Amazon, primiparous women attested that the antenatal education was particularly significant for them to gain the knowledge required for them to manage the birthing process successfully (Marsland, Meza, de Wildt & Jones, 2019: 6). Therefore, based on such results, one could conclude that formal antenatal childbirth education is probably directly proportional to a positive birthing experience for a woman and its significance and relevance should not be underestimated.

In South Africa the National Department of Health, which holds the responsibility of outlining the content of preparation for the birthing process, has attempted to do so in the form of guidelines.

However, there are no specific details regarding the steps and process of such preparation, even though midwives by virtue of their training can be assumed to be knowledgeable about the information regarding birthing process preparation. Effective sharing of such information is questionable due to the lack of a clear framework guiding birthing process preparedness of first-time mothers. In addition to the maternity care guidelines, the National Department of Health further introduced the Mom-connect messaging programme (Mom-connect), the main objective of which is sensitising pregnant and delivered women who gave birth to relevant health education (Skinner, Delobelle, Pappin, Pieterse, Esterhuizen, Borron & Dudley, 2017: 2).

Mom-connect, which was introduced in August 2014 as a means of assisting with birthing process preparation, addresses important behaviours associated with improved maternal and infant health (Barron, Peter, LeFevre, Sebidi, Bekker, Allen, Parson & Benjamin, 2017: 3). However, the programme merely conveys vital information to the mothers regarding pregnancy, labour, birth and post-natal care depending on the woman's gestational or neonate's age and what the concern is at that time. Nonetheless, the effectiveness of Mom-connect regarding preparation for the birthing process remains unclear to the midwives who have no control and do not receive these messages as they are merely programmed for pregnant women and those women who have already given birth.

Birthing process preparedness has been associated with long-term implications for the woman's health and her well-being (Kalstrom, Nystedt & Hildingsson, 2015: 1). For example, the examinations and interventions associated with the birthing process may result in distress for a first-time mother and result in a negative birthing experience (de Klerk, Boere, van Lunsen & Bakker, 2018: 90), especially if those interventions were not discussed prior to the birth. As a consequence of which can lead to the relationship of a woman and attending midwife being affected by a failure of prior birthing process preparation. Holistic preparation for the birthing process is therefore crucial.

Amongst other inevitable birthing procedures, there are birthing pains which are a part of the birthing process. Although James and Hudek (2017: 36) maintain that birthing pain is a universal feeling; but the perception is that such pains and responses differ from person to person.

Furthermore, Dixon, Skinner and Foureur (2014: 372) have also commented that, at the beginning of the birthing process, a woman may portray excitement and anticipation; but as labour progresses, the woman can become overwhelmed and lose control (Dixon et al., 2014: 373). According to these authors it is at this stage that the woman is perceived to be uncooperative by some midwives. It is for this reason that psychological preparedness for the birthing process is deemed to be very important.

This study sought to explore and describe the birthing process preparedness of first-time mothers in the public obstetric units of the NMBHD. The information gathered was used to formulate recommendations for the midwives and nurse managers that would aid them in facilitating birthing process preparedness of first-time mothers for their birthing process in public obstetric units in the NMBHD.

### 1.3 Problem statement

As a clinical and academic midwife, the researcher had constantly observed women demonstrating disapproval of necessary examinations and interventions during the birthing process and thus disobeying instructions. The occurrence of this behaviour was observed to be prevalent among first-time mothers. During informal discussions with first-time mothers, it seemed that those first-time mothers expected a brief, painless and uneventful birthing process. While others confessed to be fearing the birthing process owing to the negative stories and experiences of the birthing process shared by their peers or families.

The behaviour of the first-time mothers had thus been associated with poor birthing process outcomes and ‘unnecessary’ caesarean section (Hassanzadeh et al., 2019: 6). Available literature proved that women who were formally prepared for the birthing process, had much better birthing outcomes (Duncan, Cohn, Chao, Cook, Riccobono & Bardacke, 2017: 2). There is, however, a paucity of literature in this regard in South Africa and in the NMBHD. Mom-connect and national maternity care guidelines (Peter, Peter, Benjamin, LeFevre, Barron & Pillay, 2018: 1; Malherbe, Woods, Aldous & Christianson, 2016: 669) as strategies to improve maternal outcomes in South Africa were also questionable for effectiveness and too non-specific regarding birthing process preparation.

Furthermore, since midwives at obstetric units believed that poor understanding of the birthing process by first-time mothers put strain on them, the main question this study aimed to respond to was:

- *How ready were first-time mothers for their birthing process?*

## 1.4 Purpose of the study

The purpose of this study was to understand how was the birthing process preparedness of first-time mothers in the public obstetric units of the NMBHD. Thus, an indication of how ready they were when the labour started. The data generated was used to formulate recommendations for the midwives and nurse managers that would aid them in facilitating the birthing process preparedness of first-time mothers in public obstetric units in the NMBHD.

## 1.5 Objectives of the study

The objectives of this study were to:

- explore and describe the birthing process preparedness of first-time mothers in the public obstetric units of the NMBHD and
- formulate recommendations for the midwives and nurse managers that would aid them in facilitating the birthing process preparedness of first-time mothers in public obstetric units in the NMBHD.

## 1.6 Clarification of concepts

Since the clarification of concepts was an important step in this study document because it assisted in precise understanding of the proposed research study. For this reason, the following concepts used in the proposed study were clarified:

### *1.6.1 Birthing process*

Birth is defined as a physiological process characterised by regular, rhythmic and often painful contractions that lead to the expulsion of the baby (Martin, 2014: 249; Dippenaar & de Serra, 2018: 372).

Preparation for birthing starts at an antenatal care clinic and culminates in the birth of the baby; but is only completed at the end of six weeks postnatally, hence being referred to as the birthing process. In this study, however, 'birthing process' would include only antenatal and intrapartum periods.

### *1.6.2 Preparedness*

According to the Oxford South African Secondary School dictionary (2010: 481), preparedness "is the state of being ready." For the purpose of the study preparedness meant the state of being ready for the birthing process in the context of physical, emotional and psychological aspects.

### *1.6.3 First-time mother*

The Oxford South African Secondary School dictionary (2010: 400) defines the word 'mother' as a "female parent." For the purpose of this study a 'first-time mother' would refer to a woman who gave birth to a live baby for the first time. The study would have disregarded the parity of women in general.

### *1.6.4 Midwife*

The International Confederation of Midwives (ICM) states that a midwife is a person who has successfully completed a midwifery education programme that is duly recognized in the country where it is located (ICM, 2017: paragraph 1). Midwives comply with criteria for the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education (ICM, 2017: paragraph 1). In this study 'midwife' refers to a person registered by the South African Nursing Council (SANC); and, as such, aids in the parturition of the woman.

### *1.6.5 Obstetric unit*

An obstetric unit is a unit concerned with the labour and birth care of a woman provided by a team of midwives and doctors. Midwives care for women with uncomplicated pregnancies during labour, while obstetricians care for women who are high-risk or who develop complications during labour and birth (Cronjé, Cilliers & Pretorius, 2014: 724). In this study and obstetric unit refers to all the public institutions which are eligible to conduct birthing process at the NMBHD.

## 1.7 Research design

The research design is the researcher's choice of the optimal way to answer the research questions (Gray, Grove & Sutherland, 2017:676). Therefore, the research design is considered only once the problem statement, research questions and research objectives have been identified. The research design for this study was qualitative research one that used exploratory, descriptive and contextual approach. In order to gain an understanding of the level of the birthing process preparedness of first-time mothers in the NMBHD public obstetric units. A detailed discussion of the applied research design is discussed in chapter three.

## 1.8 Research methods

Research methods are the techniques used by researchers to structure a study, gather and analyse data relevant to the research questions at hand (Polit & Beck, 2018: 416). The idea is to use suitable research methods that are most appropriate to address the research question, thus maximising the validity of the research findings (Brink, van der Walt & van Rensburg, 2018: 187). Research methods for this study included research population, sample methods and sample size, data collection process, data analysis and pilot study which are briefly discussed below.

### *1.8.1 Research population*

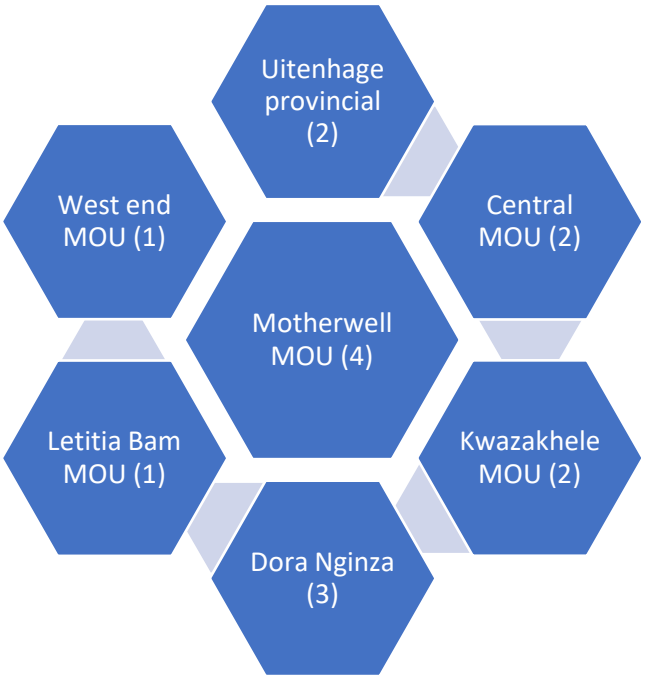
A research population is said to be a large collection of individuals or objects that is of interest to the researcher and meets the criteria of a scientific query at hand (Brink et al., 2018: 116). The target population for this study was the first-time mothers who delivered at any of the seven NMBHD public obstetric units; met set inclusion and exclusion criteria; and gave permission to participate in the study.

### *1.8.2 Sampling methods and sample size*

Polit and Beck (2018: 417) define sampling as a process whereby a portion of the population that will represent the entire population is selected. In this study convenience, non-probability sampling was used in selecting first-time mothers who delivered in any of the NMBHD public obstetric units and who met set inclusion criteria. The potential participants were recruited in the post-natal wards of each delivery unit.

The researcher used delivery registers for these purposes. Of the sixteen participants that formed the sample size of this study only fifteen were used as one interview was with a participant who was found not to have met inclusion criteria only during the interview. The distribution of the research sample size is shown in Figure 1.1 below.

**Figure 1.1: Distribution of research sample size.**




### *1.8.3 Data collection process*

Data was collected only following the granting of permission to conduct the study by the Nelson Mandela Department of Nursing Science (DNS) research committees and others such as FPGSC, REC- H (reference number: H18-HEA-NUR-021). Also, by the various relevant authorities, such as the Eastern Cape Department of Health (reference number: EC_201905_021), Chief Executive Officers, Nursing Service managers, unit managers and participants (See annexures A, B, C and D). The researcher made use of gatekeepers who were midwives and unit managers in the NMBHD obstetric units and could reach the participants.

The data collection method was one-on-one semi-structured interviews with open-ended questions. The researcher conducted interviews with women who had given informed consent to participate in the study.

Interviews were predominantly conducted within the obstetric unit premises except for one interview which was at the participant's home. The interviews were captured on a voice-recorder, after the participants had given permission for its use. The questions were primarily in English but translated into isiXhosa for some Xhosa-speaking participants, based on their preferences. Participants were expected to respond in English but were also allowed to express their experiences in isiXhosa as well as the researcher was familiar with both languages. Moreover, probing questions were posed to explore for additional data (Gray, Grove & Sutherland, 2017: 259). The research process is discussed in detail in chapter three.

### *1.8.4 Data analysis method*

Data analysis is the process of interpreting collected data by reducing and organising it to give explicit meaning (Grove, Gray & Burns, 2015: 47). The data analysis in qualitative research studies is done simultaneously with data collection (Grove et al*.,* 2015: 88). According to Harvey and Land (2017: 278), data analysis is targeting understanding of explicit meaning and portrayal of the phenomenon at hand.

For this study the thematic method of data analysis was used to analyse data (Harvey & Land, 2017: 284) using the following steps:

- The researcher familiarised himself with transcribed data.
- The researcher generated preliminary codes to data in order to describe the content.
- The researcher searched for patterns or themes in assigned codes across different interviews.
- The researcher reviewed themes.
- The researcher defined and named themes.
- The researcher produced the report.

The data analysis of the collected data yielded the following three main themes.

- Theme 1: Participants shared their experiences regarding the birthing process and their birthing process preparedness.
- Theme 2: Participants expressed having had varied experiences from factors that had influenced their birthing process preparedness.

- Theme 3: Participants provided suggestions for midwives to facilitate their birthing process preparedness.

There were also sub-themes and categories that were simultaneous with the main emerging themes. An in-depth application of the thematic method of data analysis and a detailed discussion of the final findings will be in chapters three and five respectively.

### *1.8.5 Pilot study*

A pilot study, which is conducted on a scale limited but similar to that of the main study uses the same methods as those of the main proposed study (Harvey & Land, 2017: 296). Pilot studies allow a researcher to identify areas that will need alteration prior the beginning of the main study (Harvey & Land, 2017: 169). For this study one participant from each of the three of the seven purposively selected obstetric units in the NMBHD was used for the pilot study. The results of the first pilot study were declined by the supervisor as there were noted to be problems with data collection (See chapter 3). After having implemented the suggestions, the researcher conducted the second pilot study following the same methodology.

Since the results of the pilot study were then accepted, they were included in the main study. Ultimately sixteen interviews were conducted; but only fifteen interviews were used because one participant was found not to have met the inclusion criteria during the interview.

## 1.9 Trustworthiness of the study

The quality of a research study is of great significance since it should ensure trustworthiness in the research findings. Polit and Beck (2018: 69) highlight the fact that there is a certain scientific merit standard to which qualitative research should adhere in order to correspond with the ethical standard of trustworthiness. While Grove et al. (2015: 392) attest that trustworthiness is confirmation that the qualitative study has rigour and is of high quality. For the purpose of trustworthiness of this study, the criteria that were used were credibility, transferability, dependability and confirmability as proposed by Lincoln and Guba's model of trustworthiness (Polit & Beck, 2018: 69). Further discussion thereof will be presented in chapter three.

## 1.10 Ethical considerations of the study

Ethical issues arise in the context of health research when it comes to collecting, storing and using individual data. Polit and Beck (2018: 77) highlight a concern of a grey area between what constitutes the expected practice of nursing and data collection in order to adhere to the principle of non-violation of human rights. The ethical principles that guided the research with human participants were the principles of respect for persons, beneficence, non-maleficence and justice. These principles and their applications in this study are discussed in chapter three.

## 1.11 Chapter layout

The chapter layout for the study is shown below.

**Table 1: Chapter layout**

| | |
|---|---|
| Chapter 1 | Overview of the study |
| Chapter 2 | Literature review |
| Chapter 3 | Research design and methods |
| Chapter 4 | Data analysis and presentation of findings |
| Chapter 5 | Discussion of findings |
| Chapter 6 | Summary, limitations, recommendations and conclusion |

## 1. 12. Conclusion

Ill-preparation for birthing process preparedness appears to be a shared phenomenon among first-time mothers, particularly in the NMBHD and in South Africa generally. There is a paucity of literature neither to support nor reject the above observed phenomenon. In well-resourced countries there is a record of birthing process preparation which leads to birthing process preparedness, readiness and a positive birthing process in concerned women. In contrast, women who are ill-prepared for their birthing process often object to birthing process procedures, resulting in unnecessary

medical interventions. They therefore view their birthing experience as negative. Chapter two will explore the literature review of this study.

# CHAPTER 2

# LITERATURE REVIEW

## 2.1 Introduction

Chapter one presented an overview of this study. Chapter two gives a presentation that describes the activities involved in conducting a literature search for the study. In this presentation the researcher will include some of the study concepts that were unpacked to yield meaning to the gap identified for the need of the study. The material for the literature review was drawn from journals, books, theses, peer-reviewed articles and consultation with midwifery experts.

## 2.2 Literature review

Polit and Beck (2018: 107) define a literature review as the summary of evidence regarding the identified phenomena. Joubert and Ehrlich (2012: 66); Harvey and Land (2017: 185) all agree that a literature review should not merely be a summary of evidence regarding the phenomenon but should also present a critical examination and synthesis of the existing relevant literature. The general understanding of a literature review is that it seeks to present a viewpoint of a phenomenon, together with a discussion of the strengths and limitations of the underlying research (Joubert & Ehrlich, 2012: 66). According to Brink et al. (2018: 57), a literature review should be extensive and inclusive of all the relevant literature. The researcher therefore consulted a variety of sources in order to meet the accepted standards of a literature review.

The conception of this study developed from observations of birthing women; particularly first-time mothers, who unintentionally disobeyed midwives' instructions during their birthing process. There seemed to be poor birthing process preparedness among first-time mothers who in some cases appeared to have expected brief, uneventful or positive birthing processes or experiences, having been influenced by what they had heard from their peers and or families.

Owing to this assumption midwife were at times compelled to use non-appropriate but not harmful interventions when attending to the needs of women who were ill-prepared for their birthing process.

The provision of birthing process preparation is thus likely to be inconsistent in South Africa as specific guidelines for facilitating birthing process preparedness of first-time mothers in the country are lacking. The literature that was found about first-time mothers' birthing experiences revealed that women who were well prepared for their birthing process had much better birthing outcomes (Duncan et al., 2017: 2).

### *2.2.1 The literature search process*

The primary rationale for literature reviews is the comprehensive depiction of what is known and not known about the phenomenon of interest (Harvey & Land, 2017: 185; Grove et al., 2015: 163). One would say that literature review prevents one from duplicating a previously explored phenomenon; therefore, the phenomenon for the context of this proposed study is birthing process preparedness of first-time mothers. Grove et al. (2015: 164) state that differences in purposes, extent and timing of literature reviews exist among qualitative research approaches. For example, literature reviews are expected to provide a framework for data collection approaches (Grove et al., 2015: 164). According to Brink et al. (2018: 58), literature reviews further identify instrumentation knowledge for validity, reliability and avenues to follow.

The purpose of the literature review in this study was to illustrate the current practice to enhance birthing process preparedness in first-time mothers and in general. Also, to determine the extent of poor birthing preparedness, associated adverse effects and, moreover, the need to enhance birthing process preparedness among first-time mothers. To inform and support the findings of this study the literature review was therefore conducted before and after data collection.

For this study a variety of databases was used to conduct the search which included Google Scholar, Medline, PubMed, Cochrane library, CINAHL, Research gate and Curationis journal. The time reference was from 2011 to 2021. The key words that were used to search the relevant literature included antenatal care, birthing process, first-time mothers, birthing process preparation,

birthing experiences and delivered women. The literature search yielded to approximately 80 articles; but not all articles that were viewed were used in the study, only those relevant to the study.

### 2.3 The birthing process

The WHO (2016: ix) applauded the ANC strategy as one of the most widely acceptable one to improve maternal and child health. ANC is the gateway for formal preparation of the birthing process across the board and subsequently in the South African context. In view of its importance the country has since adopted the BANC plus model (Hofmeyr & Mentrop, 2015: 903). The BANC plus model primarily advocates for monitoring pregnant women more frequently than the usual visits designated in the previous and original BANC model (Hofmeyr & Mentrop, 2015: 903; DoH, 2016: 38). Therefore, as indicated in the BANC plus model a woman needs to attend a minimum of eight follow-up ANC visits (Dippennaar & de Serra, 2018: 241), provided that the concerned woman is a low-risk mother at the time of booking.

In 2002, owing to stubbornly increasing rates of maternal mortality, the DoH published the first guidelines for maternity care in South Africa. Malherbe et al. (2016: 669) are of the opinion that the need for the existence of guidelines for maternity care in South Africa was reasonable due to the increases in the maternal mortality rate because of the HIV/AIDS epidemic. The maternity care guidelines provide a practical approach for primary healthcare to manage pregnancy, labour and delivery in South Africa with a focus on reducing maternal mortality. Malherbe et al. (2016: 671) attest that the latest maternity care guidelines sought to address goal three of the sustainable development goals (SDG).

Overall, objective three of the SDG seeks to ensure healthy lives and promote well-being for all (WHO, 2021: paragraph 3). The guidelines for maternity care in South Africa (2016: 29) highlight birthing process preparedness with the focus being mostly on the physical and psychological aspects of birthing women. The principal focus of these guidelines appears to be on the clinical obstetric viewpoint of care with little interest in the preparation of birthing women. As there is no mention of the content and clear guidance regarding the execution of the above-mentioned birthing process preparation and the execution of birthing process preparation remains questionable to the midwives.

In August 2014 the South African Department of Health launched the Mom-connect programme which is a free text-messaging programme for pregnant and delivered women. The registration of which is done at public health clinics by a healthcare worker and is anticipated to be a swift process (Skinner et al., 2017: 2); therefore,

the chances are that only ANC booked women will be registered on the Mom-connect programme database and have access to the service rendered. For encouraging women to book early and attend a clinic regularly, that step is good; but for information access it is bad as some of these women struggle to attend a clinic from a variety of barriers. Also, as a shortcoming, Mom-connect merely dispenses vital information regarding pregnancy, labour, delivery and post-natal care according to the woman's gestational age (Barron, Peter, LeFevre, Sebidi, Bekker, Allen, Parson & Benjamin, 2017: 3) but addresses no physical questions nor does it provide an answer slot. Two weekly messages about health information, parenting support and fetal development that match the gestational age or age of the new-born are sent from this programme (Peter et al., 2018: 2).

The Mom-connect service is meant to complement available services by empowering mothers to take better care of their children (Skinner et al., 2017: 2); yet the matter of birthing process preparedness is still not catered for in this programme which is supposed to be a strategy to optimise positive birth outcomes. Nonetheless, the programme seems to be assisting as, in a study done to assess the Mom-connect programme, results confirmed that first-time mothers reported to having drawn support and confidence from the Mom-connect messages (Skinner et al., 2017: 4).

In comparison with other similar initiatives in low-resource countries, Mom-connect programme had an outstanding response of more than 60% from its target population in 2017 (Peter et al., 2018: 1). At least 1.7 million women had subscribed to Mom-connect since its conception (Peter et al., 2018: 3). Sadly, however, despite having been hailed positively, there were associated downfalls. For example, the results of a study that was conducted in 2015 showed that Mom-connect had accessed only 50.8% women in Limpopo province (Barron et al., 2018: 4). In such instances one could therefore question the whole level of access of pregnant women to the Mom-connect service, particularly the first-time mothers who could be in desperate need of the necessary information regarding birthing process preparation.

Furthermore, Peter et al. (2017: 2) have highlighted the fact that one out of four candidates who were willing to register subsequently abandoned the registration due to time-outs and network problem. The previous statement suggests that complete coverage to expectant women is not feasible.

SMS is also said to be limited because it allows for the use of only 60 characters which from the researcher's viewpoint, could be too limited for birthing process preparation (Peter et al., 2017: 2). Moreover, Peter et al. (2017: 3) argue that a change of cell phone number is the biggest pitfall, which burdens the budget that is already deprived. Based on the proposed objective of the Mom-connect programme, it is evident that upon its inception there was probably no or little interest in addressing birthing process preparedness. Therefore, the birthing process preparedness could be addressed only coincidentally through the Mom-connect programme. Consequently, the effectiveness of Mom-connect in terms of birthing process preparation remains unclear to the midwives.

Essentially, the birthing process is a physiological process characterised by regular, rhythmic and often painful contractions that lead to the expulsion of the baby (Martin, 2014: 249). The birthing process originates primarily from the combination of hormonal and mechanical factors which in turn result in painful contractions coupled with cervical dilatation and eventually the birth of the baby (Dippenaar & de Serra, 2018: 372). The literature suggests that normal birthing process is acceptable if it occurs between 37 and 42 weeks and is completed within 18 hours (Dippenaar & de Serra, 2018: 372). It is, however, worth mentioning that Dixon et al. (2014: 371) highlight the fact that the birthing process is hard work which is why it is called 'labour' and during which expectant women sometimes endure long hours of pains and anxiety. In this context, Macdonald and Maggil-Cuerden (2012: 463) attest that first-time mothers particularly can experience emotional and cognitive transformation during the birthing process. In support of the above authors, Adama, Foumane, Olen, Dohbit, Meka and Mboudou (2015: 608) suggest that becoming a mother is attached to emotional distress in addition to an anticipated pleasure. One could therefore conclude that the birthing process foreseeably affects the birthing women holistically, hence the advocating of adequate birthing process preparedness.

## 2.4 A global overview of preparation for the birthing process

The WHO (2016: ix) globally provides an ideal roadmap for birthing process preparation for all pregnant women. In well-resourced countries such as the USA, the literature endorses antenatal education classes for that preparation. Primarily antenatal classes facilitate expectant women's understanding of the childbirth process, birthing milieu, the partner's role, what could go wrong during birthing, pain relief advantages and disadvantages (Barimani, Frykedal, Rosander and Berlin (2018: 1). Attendance at antenatal classes is known to be helpful in achieving more optimal peri- and post-natal outcomes (Kacperzyk-Bertnik, Bartnik, Symonides, Sroka-Ostrowska, Dobrowolska-Redo & Romejko-Wolniewicz, 2019: 492). Moreover, antenatal classes facilitate experience exchange and provide emotional support from other women in similar circumstances. According to Abbyad and Robertson (2011: 47) birthing women seek their birthing process preparedness through taking formal classes, scrutinizing through reading materials, weighing advice given and observing other women. Therefore, the primary purpose of birthing process preparation is to enhance women's knowledge of her birthing process through available strategies such as antenatal education classes.

Confirming the practice of ANC classes, Barimani et al. (2018: 1) indicate that antenatal education is a continuing norm in most Western countries to help expectant women deal with anticipated changes. As stated, in USA birthing process preparedness is in the form of childbirth classes is an organised system (Abbyad & Robertson, 2011: 46). Interestingly enough, in Sweden antenatal classes are specifically for first-time mothers and have been a long continuing tradition (Barimani, et al., 2018: 1). In Australia as well women are formally prepared for their birthing process through antenatal classes (Lavett & Dahlen 2019, 1). Fundamentally, childbirth antenatal classes address birthing process preparedness specifically and findings of a study done by Barimani et al. (2018: 4) demonstrate that 67% of the antenatal course was allocated merely to birthing process preparedness. Covering mainly, length and stages, possibility of complications, and possible tearing requiring cutting of the episiotomy (Barimani et al., 2018: 4).

At this stage one could conclude that literature corroborates the effectiveness of antenatal classes for birthing process preparation in well-resourced countries,

whereas in low- to middle-resourced countries there appears to be a diverse range of birthing process preparation. To endorse the above statement, the literature reports that Malawi is in a possession of an antenatal education strategy as a continuing norm similar to that of well-resourced countries (Chikalipo, Chirwa & Muula, 2018: 2). It is mentioned that in Malawi antenatal education is said to improve the health of mothers, their babies and their families (Chikalipo et al., 2018: 2).

The discussion in those antenatal education sessions is, amongst others, intrapartum education which contributes to enhancing the chances of a timely birth by skilled attendants (Chikalipo et al., 2018: 9) because women are informed about the signs of labour and expected responses, therefore, the content of antenatal education in Malawi and USA appearing therefore to be comparable. Hence, the outcomes also likely to be comparable. In Kenya the quality of both provision and experience of ANC are observed to be sub-optimal as that country is plagued by demographic and socio-economic factors (Afulani, Buback, Essandoh, Kinyua, Kirumbi & Cohen, 2019: 1). Consequently, relevant to birthing process preparation, a substandard communication for birthing women was reported by midwives (Afulani et al., 2019: 1) indicating that birthing women appeared to have missed opportunities of being educated on topics about the birthing process in preparation of their birthing era.

On the other hand, in other countries such as Tanzania, after a need for birthing process preparedness had been identified, there was a proposal for the development of an antenatal group education programme (Shimpuku, Madeni, Horiuchi, Kubota & Leshabari, 2018: 2). The proposed antenatal education programme has been recognized to enhance the knowledge and birth preparedness among pregnant women in that country (Shimpuku et al., 2018: 10). To this end the literature indicates the need for quality antenatal education as an effective means to improve birthing process preparedness of birthing women.

There is little or no literature in countries such as Kenya, Nigeria and Ghana regarding antenatal education classes specifically and the literature available suggests that those countries integrate their antenatal education into ANC clinic visits in anticipation of women's birthing process preparedness. For example, in a study done in Nigeria, 45.7% of women argued that four visits were not adequate for them to learn what they needed to know and establish meaningful relationships with their care providers

(Aniebue & Aniebue, 2010: 426). Congruent to the above study, in a study done in Ghana, one participant reported that the reason she was poorly prepared for her birthing was that she booked late for the ANC clinic and consequently missed the covering of some important topics (Konlan, Japion & Konlan, 2019: 1650). In contrast to the above study findings, however, a study done in Kenya found that 26% women who had had four or more antenatal care clinic visits were better prepared for birth than the 15% of those who did not attend (Gitonga, Keraka & Mwaniki, 2016: 155). The antenatal education in anticipation of birthing process preparation is integrated into ANC clinic visits; but its provision is diverse among low-to-middle-resourced countries. As such, there appears to be diverse experience of the actual birthing process preparedness as a result of how antenatal education is conducted.

In addition to antenatal education classes as the source of information to enhance women's knowledge of birthing process preparedness, thus their readiness, Sander and Crozier (2018: 1) and Abbyad and Robertson (2011: 46) noted the norm of informal antenatal childbirth education to have been a continuing practice globally. Expectant women can access large volumes of information about their birthing process to enhance their birthing process preparedness and readiness from sources including the Internet, family and friends, popular media such as newspapers and television, written material from professional and commercial entities (Martin, Bulmer & Pettker, 2013: 103; Sengane, 2013: 1; Sander & Crozier, 2018: 1). The literature refers to these sources as informal antenatal education.

Informal antenatal education is further acknowledged to be the birthing process experience that is passed from mothers to daughters or from traditional birth attendants (Sander & Crozier, 2018: 1). But some studies highlight the fact that not all sources of antenatal education provide accurate, helpful or relevant information. Klomp et al. (2016: 96) found that the danger of informal antenatal childbirth education was that it sometimes made women insecure and rather fearful with regard to the birthing process because of the potential of exaggerating the extent or negative possibilities associated with the birthing process. The effectiveness, therefore, of informal birthing education is questionable as it has the potential to result in women doubting their birthing process coping abilities (Duncan et al., 2017: 2).

Discussions with health professionals such as midwives are accepted as being the most predominantly used and reliable information for birthing process preparedness. For example, in Malawi it was found that discussion of signs of labour enhanced timely birthing by a skilled attendant such as a midwife (Chikalipo et al., 2018: 10) although some of the birthing women reported having not received adequate information from health professionals (Munkhondya, Munkhondya, Msiska, Kabuluzi, Yao & Wang, 2020: 308). Consequently, having to consult varied sources for the said information, it appears that adequate access to varied sources for birthing process preparedness continues to be needed for the required level of preparedness to be implemented throughout all levels of society. Midwives are to validate that information and dispel myths or harmful information at ANC clinics (Chikalipo et al., 2018: 1).

### 2.5 Benefits of birthing process preparedness

According to available literature, benefits of birthing process preparedness are mainly from obstetrical, women's experiences and the emotional perspective. For example, in Ghana most expectant women proceed to birthing process unprepared (Konlan et al., 2019: 1645) a phenomenon which could culminate in a negative birthing experience in instances where birthing process diverges from what has been hoped for and anticipated. Namujju, Muhindo, Mselle, Waiswa, Nankumbi and Muwanguzi (2018:1) are of the view that negative birthing experiences may lead to unwanted effects including reduced love for the baby, emotional upsets, post-traumatic disorders and depression. Furthermore, since about 99% of mortalities that occur in developing countries are a result of expectant mothers' deficiency in preparedness for their birthing process (Konlan et al.,2019: 1645). Therefore, birthing process preparedness appears generally to offer improvement in maternal and child health.

As the birthing process preparedness in most countries is gained through antenatal education classes, in Brazil, for example, antenatal education is aimed at preparing women for labour by providing information and practising physical exercises, breathing and relaxation (Miquelutti, Ceccati & Makuch, 2013: 2). As such, women who have participated in antenatal education in Brazil are reported to have maintained self-control during their birthing process as they used breathing exercises, the birthing ball and other non-pharmacological strategies to control pain (Miquelutti et al., 2013: 1).

Benefits of the above-mentioned form of birthing process preparation could be wide-ranging, for example, from the obstetrical point of view, in Italy a standardized antenatal class was shown to have reduced the high rate of caesarean sections amongst birthing women (Cantone, Lombodi, Assunto, Piccolo, Rizzo, Pelullo & Attena, 2018: 2). As increased use of obstetrical interventions such as caesarean sections are believed to be associated with complications and should therefore be advocated only when obstetrically and medically indicated.

In conjunction with obstetrical benefits, birthing process preparedness also aids in curbing negative feelings associated with poor birthing process preparation, such as fear of the birthing process which appears to be prominent among birthing women. The literature suggests that fear of the birthing process escalates particularly among poorly prepared first-time mothers who often request caesarean sections (Matinnia, Faisal, Juni, Moeini & Osman, 2015: 1121). There are numerous reasons culminating in women fearing the birthing process, some of which are lack of birthing process knowledge, fear of complications resulting in harm to the unborn baby and inability to cope with pain (Slade, Balling, Sheen & Houghton, 2019: 1). As such, fear of the birthing process is believed to complicate what could have been a healthy adjustment of a birthing woman (Duncan et al., 2017: 2). Furthermore, Slade et al (2019: 1) attest that fear of the birthing process is associated with negative birthing experiences and mental health difficulties, amongst others. Macdonald and Magill-Cuerden (2012: 524) maintain that ideally antenatal classes should assist women towards a greater understanding of pain management and introduce them to coping strategies. In this regard, the literature suggests that women tend to double the ability to cope with birthing process pains if they have been exposed to those coping strategies (Duncan et al., 2017:2).

If it is a general fact that women are fearful as a result of insufficient birthing knowledge (Slade et al., 2019: 1) then ANC clinics, particularly from the midwives in that environment, should ensure emphasize reasonable provision of information to pregnant women (DoH, 2016: 29). According to Javanmardi, Noroozi, Mostafavi & Ashrafi-rizi (2019: 1), birthing process information is crucial because it enhances acceptable healthy behaviour, self-care and empowerment for the birthing woman.

## 2.6 Expectations of women regarding birthing process preparedness

Available literature shows that varied expectations of women regarding their birthing process exist (Hildingsson, 2015: 7). These expectations align with institutional or environmental categories and that of the birthing process and midwives. The literature suggests that the birthing process expectations play a vital role in determining women's response to her birthing process (Pirdel & Pirdel, 2015: 16). Literature further noted that the contributors to these expectations are the woman's level of education, attendance at prenatal education programmes, previous birthing experiences, influence of authority figures and the stories they hear from friends or families and the media (Sengane, 2013: 1). These contributors could lead to the adverse reactions as some of the expectations, especially that of uncomplicated birth of healthy babies, may not be fulfilled. In circumstances where those expectations are not fulfilled, concerned birthing women potentially portray powerful feelings such as disappointment and anger (Dippenaar & de Serra 2018: 584). Although they may have attended an ANC clinic, women who often have unrealistic expectations of the birthing process may require a collaborative approach as not all of them are categorically from the midwifery domain. ANC clinics should therefore aim to curb those that are midwifery related. Pirdel and Pirdel (2015: 16) maintain that healthcare providers are supposed to improve the quality of ANC which can prevent negative birthing process experiences and improve the experiences of women generally.

Birthing women have at times physical expectations. For example, in a study done by Sengane (2013: 5) it was found that participants expected midwives to rub their backs and abdomens, assist them in assuming a comfortable position and hold their hands during their birthing process. Fulfilling of these expectations could be challenged by institutional policies such as midwife/patient ratio and other midwives' responsibilities; thus, fulfilling those expectations becomes impossible. Birthing women should be educated about reasonable expectations for their birthing process to avoid disappointment and negative birthing process experiences. In a Swedish cohort study done by Hildingsson (2015: 7), women shared the childbirth experiences as having been worse than they expected; for they appear to have had higher expectations which some were less likely to be fulfilled, for example, physical support from the midwives (Hildingsson, 2015: 7).

The literature shows that there could be physiological expectations from birthing women as well, for example, the ability to cope with birthing process pains. In a study done in Kenya on women's expectations and childbirth experiences, women commented that they had expected tolerable pains (Okwako & Symon, 2014: 1). Furthermore, other women seem to expect a combination of positive birthing experiences, positive outcomes and unlimited expertise of birth attendants. These expectations include respect and dignity, timely communication, competent and skilled staff and availability of medical supplies (Kyaddondo, Mugerwa, Byamagisha, Oladapo & Bohren (2017: 38). Since such expectations may be prominent amongst the first-time mothers as they do not have a previous experience of birth to draw from, these expectations need to be explained by midwives as they can potentially, amongst other aspects, impair the woman/midwife relationship.

## 2.7 Role of midwife regarding birthing process preparedness

By virtue of their profession midwives work in a partnership with women to give necessary support, care and advice during pregnancy, labour and during the postpartum period (ICM, 2017: 1). Midwives, therefore, need to possess acceptable knowledge and skills to care for birthing women (Koroglu, Surucu, Vurgec & Usloglu, 2017: 52). Midwives are compelled to have developed these skills as they are obligated to educate mothers about antenatal exercises including preparation for labour and breastfeeding (SANC: np). Therefore, the role of the midwife to enhance birthing process preparedness of a women appears to be two-fold which involves physical skill and communication.

In a study done by Thorstensson, Ekstrom, Lundgren and Wahn (2012: 4) about exploring professional support offered by midwives during labour, midwives were found to be more concerned about midwifery related tasks based on their own judgements than about providing other kinds of support, for example, feeling for contractions, performing observations, or vaginal examinations (Thorstensson et al., 2012: 4). According to Mutabazi and Brysiewicz (2021: 4), the above-mentioned roles of midwives are referred to as professional support which includes informing the birthing woman of her progress through the birthing process and providing that professional support to a woman to enhance her birthing process (Kordi, Bakhshi &

Tara, 2014: 7). Moreover, professional support is associated with fewer risks of medical interventions and increased positive birthing experiences (Maputle, 2018: 1; Kordi et al, 2014: 7).

On other hand midwives should emphasise the benefit of communication and provide advice to birthing woman. In a study done by Maputle (2018: 4), women acknowledged what a significant role communication, information and emotional support had played in their birthing process preparedness.

In line with the above statement, Koroglu et al. (2017: 61) attested that, midwives should maintain active communication with women, ideally from the pre-pregnancy period, during the pregnancy, labour and postpartum period. Maputle (2018: 4) stated that informational support given to birthing women by midwives was mainly about physiological and emotional support. It is, therefore, evident that the role of a midwife regarding birthing process preparedness includes physical as well as soft skills such as being understanding, friendly, communicating kindly and reassuring the woman during the birthing process.

### 2.8 Birthing process preparation in the context of South Africa

The WHO (2016: 1) as a policymaker globally accepted ANC services to be the gateway for integrated management of several conditions to safeguard against adverse effects on mothers and the fetus. Inclusive of that integrated management is being able to respond to mothers' complaints, prepare mothers for birth and promote healthy behaviours (Islam & Masud, 2018: 22). ANC advocates the promotion of relevant information to pregnant women for physical and psychological preparation for childbirth (DoH, 2016: 29). South Africa mirrored the ANC strategy and adapted it to fit into the BANC plus model (Hofmeyr & Mentrop, 2015: 903). To date, in the South African public health context, the BANC plus seems to be the only formal strategy available for birthing process preparation of the birthing or expectant mothers.

The global literature presented conflicting findings regarding the effectiveness of the methods used for birthing process preparedness (Hildingsson, 2015: 9; Tran, Gottval, Nguyen, Ascher & Petzold, 2012: 1). In South Africa little is known either about the effectiveness of ANC regarding birthing process preparedness or the experiences of

women in ANC clinics in the context of this study. However, in the study done by James, Rall and Strumpher (2012: 8) it was found that pregnant teenagers criticised ANC clinics since they were perceived to be an unwelcoming environment, an opinion that suggests a missed opportunity for a successful birthing process preparation for those women.

There are comparable global trends with those witnessed in South Africa of late ANC clinic booking and thus underutilisation of ANC clinics (WHO, 2016: 1; Kaswa, Ruperinghe & Longo-Mbenza, 2017: 1). Most of the literature often reported existing inequities in maternal health in South Africa, mainly noted in provinces such as the Eastern Cape and the North-West province (Wabiri, Chersich, Shisana, Blaauw, Rees & Dwane, 2016: 1). Studies over the years seem to have denied the completion of providing adequate access to ANC clinics for expectant women. Because of that problem one would further question the success of the ANC strategy of preparation for birth among South African birthing women. Low maternal education, stigma, teenage pregnancies, multiple parity and cultural factors are said to be among the reasons for underutilisation of ANC clinics (WHO, 2016: 1).

In South Africa predominant cultural practices are often documented to have been utilised for birthing process preparedness in addition to ANC clinics. Some of the commonly noted cultural practices regarding birthing process preparedness included diet, medicinal herbs to assist in difficult deliveries and body cleansing following miscarriage (M'soka, Mabuza & Pretorius, 2015:1). On the other hand, results from Mogawane, Mothiba and Malema (2015: 2) suggest the prominence of traditional healers as they are often the first point of contact when a person has a health problem. For example, Mogawane et al. (2015: 1) found that some women in Limpopo province had relied on indigenous practices for other aspects of their birthing process preparation. Consistent with these statements Mulondo (2020: 788) writes that factors associated with underutilisation of antenatal care services in Limpopo were found to be cultural practices and beliefs. In this regard Mogawane et al. (2015: 4) found that the indigenous knowledge which is part of a cultural tradition in these villages was often transferred from elderly people to the younger ones. Although there is little documented data in this regard, it is evident that there are some birthing women who still rely on indigenous and cultural practices in South Africa, which leads one to question professional birthing process preparedness.

Mutabazi and Brysiewicz (2021: 2) found that there was a lack of available data concerning birthing experiences including birthing process preparedness in low- and middle-income countries including South Africa. Mom-connect and maternity care guidelines as available strategies to improve maternal and neonatal outcomes in South Africa are questionable and non-specific, regarding preparation for the birthing process. To the researcher's knowledge there is inadequate, if any, documented literature which describes the preparedness of first-time mothers for their birthing process; both in the public and the private health sector. Therefore, there is no standard framework for birthing process preparation and diverse and diverse preparation could be anticipated.

## 2.9 Conclusion

This chapter examined the literature about birthing process preparedness of first-time mothers from various studies. The literature review of which crevealed that birthing process preparation was a continuing norm in well-resourced and in some low- to middle- resourced countries in the form of formal antenatal classes. Predominantly, low-resourced countries appear to have integrated birthing education into their ANC clinic visits. Some benefits of the birthing process preparation from an obstetrical as well as a birthing women's point of view have been documented.

Although midwives appear to be the key role-players in the provision of birthing process preparedness, the literature has revealed that birthing women access varied information sources to enhance their birthing process preparation. There is unfortunately a paucity of comparative studies in South Africa and in the NMBHD regarding birthing process preparedness, a lack which indicates that additional literature is needed on the phenomenon of birthing process preparedness. The following chapter will describe the research methodologies that were used in this study.

# CHAPTER 3

# THE RESEARCH DESIGN AND METHODS

## 3.1 Introduction

Chapter two provided a literature review conducted for the purposes of this study. A brief description of the research design and methods were presented in chapter one. The primary aim of this chapter is to discuss in broader perspective the research design and methods used in this study and to present a description of the data analysis method, the trustworthiness and ethical considerations adopted in this study.

## 3.2 Rationale for the study

Poor birthing process preparedness had been an observable phenomenon in the NMBHD, particularly amongst the first-time mothers. As such, the literature is of opinion that, generally the focus had been on addressing obstetric complications rather than women's experience overall (Nilsson, Thorsell, Wahn & Ekström, 2013:1). Poor birthing process preparedness amongst the first-time mothers has been noted to be the result of absence of reference since the birthing process is an unknown experience to them. Furthermore, there is no available standard tool for midwives for the preparation of women, particularly the first-time mothers for their birthing process. Thus, results in diverse expectations and preparedness amongst these women. The diverse birthing process preparedness at times is believed to lead to unfavourable effects for both expectant women and the midwife caring for the birthing women.

While it has been well documented those women who had given birth before can easily refer to their previous birthing process (Dixon et al., 2013: 10), first-time mothers are not in possession of that privilege. Consequently, these mothers tend to rely on other sources for assistance to prepare for their birthing process in addition to that of consultations with midwives. For example, among others are families and friends who make up the list of informal informers for this purpose. The risk of informal informants is that they can mislead the first-time birthing women as the information may be based on their previous and not fully explained experiences, easily having negative influence

and even posing a threat to birthing process preparedness and the positive experience desired by first-time mothers.

The researcher sought therefore in this study to explore and describe the birthing process preparedness of first-time mothers in the public obstetric units of the NMBHD. The results were used for recommendations for the midwives and nurse managers that would aid them in facilitating birthing process preparedness of first-time mother in public obstetric units of the NMBHD. The main question this study aimed to respond to, was:

- *How ready were first-time mothers for their birthing process?*

## 3.3 Objectives of the study

The objectives of this study were to:

- explore and describe the birthing process preparedness of the first-time mothers in the public obstetric units of the NMBHD and
- formulate recommendations for the midwives and nurse managers that would aid them in facilitating birthing process preparedness of first-time mothers in public obstetric units of the NMBHD.

## 3.4 Research design and methods

A research design gives an overall guide to validate answers of the research phenomenon in question while methods deal with implementation of the design (Grove et al, 2013: 256). In other words, methods are the ways in which the researcher interact with research subjects in order to meet the research objectives. Therefore, the research design and methods can be considered only after having identified the problem statement, research questions and research objectives. The researcher used the qualitative research design, with descriptive, explorative and contextual approach. A detailed discussion of the design follows below.

### *3.4.1 Qualitative research design*

Polit and Beck (2018: 415) recommend a qualitative research design when one is investigating a phenomenon in depth and in a holistic manner.

In addition, Grove et al. (2013: 57) highlight the fact that a qualitative design seeks to give subjective experience as well as, in this case, guide nursing practice. The qualitative design was therefore utilised to explore and describe birthing process preparedness of first-time mothers in the public obstetric units of the NMBHD.

Grove et al. (2013: 57) maintain that understanding is not gained by measuring the concepts or establishing the causality. These authors believe that understanding is gained through comprehension of the phenomenon of interest (Grove et al. (2013: 57), which in this study is the birthing process preparedness of first-time mothers. A qualitative design is said to be interested in the uniqueness of the person concerned and the natural holistic approach to understand true experiences, hence its usage for the benefit of seeking the depth, richness and complexity of birthing process preparedness of first-time mothers (Grove et al*.,* 2013: 57; Brink et al., 2018: 103). Descriptive, explorative and contextual approach were implemented to cover these aspects.

### *3.4.2 Explorative research*

Polit and Beck (2018: 12) highlight the fact that exploratory research begins with the phenomenon of interest**.** Polit and Beck (2018: 12); Grove et al*.* (2013: 66) agree that exploratory research seeks understanding of the phenomenon when there is little information about it by examining the nature of the phenomenon, the way it occurs and interrelated factors. Grove et al*.* (2013: 66) recommend explorative research for identifying a lack of knowledge that can be addressed only by seeking the viewpoints of people concerned, which in the context of this study is first-time mothers in public obstetric units in the NMBHD. The researcher had noted first-time mothers during their birthing process demonstrating unintentional disapproval of necessary examinations and interventions during the birthing process and refusing to obey instructions. Which questioned how much, if any, birthing process preparedness they had had. This behaviour that was mentioned was a shared phenomenon among first-time birthing mothers with multifaceted justifications from the concerned women. Since the researcher had investigated the phenomenon of birthing process preparedness, which to date had not been studied in a South African context, it was necessary to explore it.

The study aimed therefore to explore and describe birthing process preparedness of first-time mothers in the public obstetric units of the NMBHD and understand the phenomenon by gathering information about the experiences of first-time mothers regarding their birthing process preparedness. For example, he asked the question about how ready they were for their first-time birthing process experience and the role birthing process preparation had played in their birthing process. Participants' responses were explored and analysed.

### *3.4.2 Descriptive research*

Schmidt and Brown (2015: 181) emphasise that a descriptive research design provides a viewing lens into a phenomenon as it occurs naturally without manipulation of any of the variables. In agreement with the above comment, de Vos, Strydom, Fouché and Delport (2011: 96) state that a descriptive research approach is used when the researcher needs to illustrate a picture of the specific details of a situation, social setting or relationship. In this study the first-time mothers narrated their experiences regarding their birthing process preparedness and to glean information from them. Semi-structured interviews were used in order to absorb deeper meaning of the phenomenon so that a clear picture could emerge from the findings.

### *3.4.3 Contextual research*

The nature of contextual research implies that the phenomenon is studied in its natural occurrence or settings (Botma, Greeff, Mulaudzi & Wright, 2010: 195). In other words, contextual research seeks to navigate the actions of the concerned participants as they occur without being influenced by other variables. In this study the context of the study was mainly the postnatal period, a maximum of six days after the woman had given birth, either at the obstetric units, home or on a postnatal visit. The NMBHD has seven obstetric units which serve mainly Xhosa and Coloured women who have diverse cultural and religious belief systems regarding their birthing process and preparedness thereof. The population mainly expressed themselves in isiXhosa and English, were diverse in terms of age, education level and their occupations (See chapter four, table 4.1) for detailed variations.

## 3.5 Research methods

Polit and Beck (2018: 418) refer to research methods as the practices engaged to structure a study, gather and analyse data in an acceptable manner. The idea is to use research methods that are most appropriate to address the research problem and purpose, thus maximising the validity of the research findings (Brink et al*.,* 2018: 58). Research methods for this study included description of the research population, sampling method, sample size, data collection process, data analysis and pilot study. The research methods are discussed below.

### *3.5.1 Research Population*

Having noted the phenomenon and the purpose of the study, the researcher needed to define the relevant population concerned. Grove et al. (2013: 351) define population as the certain collection of individuals. In other words, a research population is a large group of individuals or collection of objects that are of interest to the researcher and meet the criteria of a scientific query (Brink et al*.,* 2018: 116). Such individuals should have experienced the phenomenon to be investigated and be able to share information from an experiential viewpoint (Gray et al., 2017: 254). In view of this study's purpose, the population was first-time mothers who had given birth in any of the seven NMBHD public obstetric units.

### *3.5.2 Sampling method and sample size*

Sampling is said to be the action of selecting a group of; people, events, behaviours, or elements relevant for a proposed study (Grove et al., 2013: 351). The literature acknowledges that it is both impractical and unnecessary to study the whole population concerned, as it is often too large, unwieldy and widespread (Brink et al*.,* 2018: 116). However, it was suggested that the researcher should optimise the use of resources for research proposed (Brink et al*.,* 2018: 116) and pick a suitable sample

To correspond with the latter statement, the researcher opted for sampling because Brink et al. (2018: 116) believe that sampling provides a more accurate viewpoint of the phenomenon being studied, which was in this study first-time mothers. The sample size was intended to be 21 participants, although it was to be guided by the data saturation. Sixteen participants were interviewed; but only fifteen of those interviews

were used. A convenience, non-probability sampling method was used in selecting participants who met set inclusion criteria because it is advocated for its ability to include participants who are readily available and meet the inclusion criteria of the study (Harvey & Land, 2017: 199). The inclusion criteria are characteristics that a subject or element must possess in order to be part of the proposed study (Grove et al., 2013: 353), in this study were the first-time mothers who:

- between the ages of 18 and 30 years old,
- had delivered a live new-born,
- were at least six hours to six days postnatal, a period that is ideal for meeting the woman as soon as possible while she can still recall the birthing process and at the same time observing consideration regarding recovery from the birthing process (James & Hudek, 2017: 38) and
- had been booked and delivered in public institutions in the NMBHD.

The exclusion criteria are said to be the characteristics that can cause a person or an element to be excluded from the target population (Grove et al., 2013: 353). The exclusion criteria for this study were first-time mothers who had had a stillbirth or a neonatal death. The above category of first-time mothers was excluded from participation to avoid emotional hurt (James & Hudek, 2017: 38) and because their previous birthing experience could potentially influence their experiences of the phenomenon being studied. The other exclusion criterion was a mother who was a high-risk case. Figure 1.1 deals with the distribution of used research sample size.

### *3.5.3 Data collection process*

The data collection process was resumed only after the researcher had been given permission to conduct the study from Nelson Mandela Department of Nursing Science (DNS) research committee. As well from FPGSC and various relevant authorities, such as the Eastern Cape Department of Health, Chief Executive Officers, Nursing Service managers, unit managers and participants**.** Midwives and unit managers were resourceful in identifying potential participants who met the set criteria at postnatal units. The delivery register was also useful for identifying potential participants, who were then immediately recruited by the researcher as soon as they were noted in the postnatal wards of the birthing unit, where they had been admitted.

These women were individually presented with a formal request to participate in the study and were requested to give informed consent if they had agreed to participate. Letter to participants (annexure A) address the aspects related to participation to the study, such as the interview location and venue, interview process, possible risks and interventions in place, possible benefits and the right the participant had to end participation without experiencing harm. The potential participants were to consent (annexure B) either to immediate participation or a postnatal visit after three to six days. (DoH, 2016: 136), based on their preferences.

The gatekeepers were asked to suggest a convenient room within the institution for data collection process. An unoccupied kitchen, manager's office, other unit's rooms inside the obstetric unit where there was anticipated to be a minimal disruption, were used. A **'DO NOT DISTURB'** sign was displayed at the door of the room to avoid disturbance and to facilitate a good interview session. The interviews commenced as soon as the women had consented to their participation. Exclusion was in situations where there would be a deliberate disturbance of hospital routine or woman requiring more time to discuss her decision with family. There was only one in that category for whom the interview was rescheduled for a convenient time slot and venue for that participant who would sign her consent form at a later stage but before her interview.

The data collection method was one-on-one semi-structured interviews that were captured by a voice-recorder. Interviews are said to focus on interaction between the researcher and participant, subsequently producing words (Gray et al*.,* 2017: 258; Grove et al., 2013:270). Semi-structured interviews are planned around a set of open-ended questions (Gray et al., 2017: 258). According to Brink et al*.* (2018: 143), overall interviews are acknowledged as the most direct method of gleaning facts relevant in exploratory research. The questions were posed in English and translated into isiXhosa for Xhosa speaking participants based on their preferences. Participants were allowed to respond using both English and isiXhosa to capture best their experiences about their birthing process readiness.

Before commencing with the interview as an introduction to the session the participants were reminded of the purpose of the study, the right of voluntary participation and/or withdrawal at any time without any sort of penalty. Semi-structured interviews lasting a maximum of forty minutes with open-ended questions were posed

to the participants; but, at the same time the researcher probed and explored for additional data (Gray et al*.,* 2017: 259). The researcher had drafted open-ended questions to produce more in-depth data in order to meet the demands of the qualitative exploratory design.

Participants were responding to the following main question:

*"Can you tell me how ready you were for your birthing process?"*

Depending on the responses to the main question by the participants the researcher also used some questions from the interview schedule. The interview schedule was as follows:

- How would you describe the preparation for your birthing process?
- How do you feel about the quality of the preparation for your birthing process provided for you during antenatal visits?
- How do you feel about the manner such as structure in which the birthing-process preparation was done?
- What effect did the preparation for the birthing have on your birthing process?
- What is it that you think should be emphasised in the birthing process preparation?

Furthermore, the researcher used probing questions that encouraged the participants to dwell more or to elaborate on the question asked. Grove et al*.* (2015: 83) define probes as queries made in to obtain further data from participant regarding interview question. For example, the researcher used probes such as

- *Can you tell me more about your birthing process readiness?*
- *Can you elaborate on your response?*
- *Can you confirm if I understand your response correctly?*

These questions assisted with enhancement of quality regarding the data collected. The researcher used bracketing to maintain the validity of the study (Brink et al., 2018:105) to avoid what was known by the researcher about the diverse birthing process preparation towards birthing process readiness occurring in the ANC clinics. The collection of data was discontinued upon reaching data saturation, sixteen participants having been interviewed; but only fifteen of those interviews were used.

Brink et al. (2012: 143) recommend that the average sample size should be twenty to thirty participants, as a very small sample results in the inability of researcher to observe participants individually. However, as no new information was emerging, interviews had to be discontinued before the minimum recommended sample size. Field notes were used to capture non-verbal information and observations of what the researcher heard, observed, experienced, and thought about during and after the interview session (Brink et al., 2018: 84). The participants mostly used body language ranging from facial expressions to mannerisms in demonstrating their feelings. Furthermore, other observed events or background noise or conversations during interviews were recorded, such as external noise such as that of a crying baby (Polit & Beck, 2018: 207).

### 3.6 Data analysis

Data analysis is the process of interpreting collected data by reducing and organising such data, to give clear and meaningful information applicable to the study being conducted (Grove et al., 2017: 47). According to Harvey and Land (2017: 278), data analysis serves the purpose of streamlining the raw data collected about the phenomenon, thereby determining the codes and thought processes that extend to allocating meaning to the data (Gray et al., 2017: 269). For this study the data analysis was done simultaneously with data collection (Grove et al., 2017: 88).

For this study, the data from voice recordings was transcribed verbatim by the researcher as soon as possible after each interview or closest, while the session details were still fresh in researcher's memory. Verbatim transcripts are credited for their ability to result in abundant data for analysis because they document participants' comments word for word (Grove et al., 2015: 68). Therefore, presenting the precise experiences and the views of the interviewed participants. The isiXhosa interviews were translated into English by the researcher, since the researcher is fluent in both languages but the supervisor who is also fluent in these languages confirmed the translations.

Interviews were transcribed onto a Microsoft Word document with responses from the researcher and participant clearly separated on the document.

On completion of transcriptions, to ensure a legitimate record of each transcript, the researcher listened carefully to the recordings against the transcripts in order to correct grammar and spelling without changing the actual essence of participants' responses. The field notes with non-verbal cues were added in the transcripts in order to enrich the depth and the context of transcribed notes. The transcripts were then kept on a password-protected computer.

The data coding process which was conducted using a thematic method of data analysis, included the following steps (See Harvey & Land, 2017: 284).

- The researcher familiarised himself with the transcribed data.
- The researcher generated preliminary codes to data in order to describe the content.
- The researcher searched for patterns or themes in assigned codes across different interviews.
- The researcher reviewed themes.
- The researcher defined and named the themes.
- The researcher produced the report.

The researcher coded the data and thereafter generated themes and sub-themes, which are the major findings of the study. All the transcripts with raw data were sent to the independent coder together with the document of objectives of the study and proposed data analysis technique required. A meeting was held with the independent coder to discuss findings which was followed by a meeting in the presence of the supervisor to finalise the findings of the study. These meetings assisted with eliminating the bias of the researcher, thus securing the quality of the research.

Three main themes and eight sub-themes emerged from the data analysis done and the main themes were:

- Participants shared their experiences regarding the birthing process and their birthing process preparedness.
- Participants expressed having had varied experiences from factors that had influenced their birthing process preparedness.

- Participants provided suggestions for midwives to facilitate their birthing process preparedness.

A discussion and full presentation of the findings is found in chapter four. Based on these findings, the researcher formulated recommendations for the midwives and nurse managers that would aid them in facilitating the birthing process preparedness of first-time mothers in public obstetric units of the NMBHD. More recommendations were further done for the purpose of nursing education and further research. The presentation of the data analysis findings is done in chapter four.

### 3.7 Pilot study

A pilot study, which is conducted on a limited scale, similar to that of the main study, uses the same methods as those of the main proposed study (Harvey & Land, 2017: 296). Pilot studies allow a researcher to identify areas that will need alteration prior to the beginning the main study (Harvey & Land, 2017: 169). For this study, three obstetrics units of the NMBHD were selected for the purpose of the pilot study based on their operational schedules and limited delivery activities. One participant was then purposively selected from each of these obstetric units. Therefore, three participants for the pilot study were considered adequate in order to evaluate and confirm the recruiting, selection, interview and probing to establish whether it was going to yield the experiences of first-time mothers regarding their birthing process preparedness.

The initial pilot interview could not be included and was rejected by the supervisor as there was no depth in the responses captured because questions asked were non-focused. After the researcher had adapted the suggestions from the supervisor, a second pilot study was conducted successfully, results accepted and these included in the main study.

### 3.8 Trustworthiness of the study

Trustworthiness is an important component of any research conducted. Brink et al. (2018: 158) maintain that every researcher aiming at producing a study of high quality has to consider trustworthiness in his/her study because the quality of the research study ensures trustworthiness of research findings. The essence of trustworthiness is

results that are meaningful, accurate and replicable (Brink et al*.,* 2018: 158). While Maree (2016: 123) maintains that trustworthiness of the study is the acid-test of data analysis, findings and conclusion. Polit and Beck (2018: 69) highlight the fact that there is a certain scientific merit standard to which qualitative research should adhere in order to correspond to the truth. Also, Grove et al. (2015: 392) attest that trustworthiness is confirmation that the qualitative study has rigour and is of high quality.

Nonetheless, Brink et al. (2018: 158) acknowledge that no data collection technique exists without possible errors; and therefore, suggest that researchers should reduce such errors to lowest possible level. For the purpose of trustworthiness of this research, the criteria that were used were credibility, transferability, dependability and confirmability as proposed by Lincoln and Guba's model of trustworthiness (Polit *&* Beck, 2018: 69).

### *3.8.1 Credibility*

Maree (2016: 123) is of the opinion that credibility of the qualitative study aims to prove the congruency of study findings in relation to reality. Furthermore, Maree (2016: 123) and Brink et al. (2018: 158) point out the significance of accuracy in a study to enable readers to believe the findings of the study. Grove et al*.* (2015: 392) maintain that credibility is a matter of demonstrating that the results of the study are solely those of the participants. Polit and Beck (2018: 69) are convinced that credibility is the most important aspect of trustworthiness. For this research the researcher used the following strategies to conform to credibility.

#### *3.8.1.1 Triangulation*

Grove et al*.* (2015: 244) highlight the fact that triangulation acknowledges the use of more than one source or reference to arrive at conclusions, clarity and/or understanding of what constitutes the truth about the phenomenon at hand. Mateo and Foreman (2014: 294) attest that triangulation strategies exist to explain a problem, which in the context of this study is birthing process preparedness of first-time mothers. While it is acknowledged that triangulation strategies may converge, be inconsistent and contradict (Mateo & Foreman, 2014:294), Brink et al. (2018: 84) are

adamant that triangulation is of benefit as it allows for neutralisation of a possible inherent bias in a particular data source when used in conjunction with others. Mateo and Foreman (2014: 293) classify triangulation into data, investigator, theory and methodological. Brink et al. (2018: 158) further highlight that triangulation includes collecting information about different occasions and their associations from differing points of view by asking different types of questions.

For this study, in addition to the main question, the researcher asked different questions during interview sessions. For example, “What effect did the birthing process preparation have on your birthing process? Furthermore, the different sources of relevant data were consulted, such as research supervisors, experts in the field of research and reproductive health care, articles and dissertations for a comprehensive literature review and findings were discussed and reviewed with the supervisor and professional independent coder who are experts in the midwifery field.

#### *3.8.1.2 Member checks*

Member checks as a strategy to conform to credibility is acknowledged by its ability to assess the actual intentions of the participants (Brink et al., 2018: 159). In essence, member checks afford an opportunity for participants to verify and correct errors of fact (Maree, 2016: 123). Immediately after each interview the researcher played back the voice recordings to the participants to confirm if they were indeed reflecting their experiences.

#### *3.8.1.3 Peer debriefing*

Brink et al. (2018: 158) advocate that experts and experienced colleagues of similar status and general understanding of the study should be sought out. For this study the supervisor and independent coder were used for the purpose of peer debriefing and seeking to arrive at a relatively similar agreement (Polit & Beck, 2014: 328).

#### *3.8.1.4 Prolonged engagement*

Prolonged engagement means that the researcher spends the maximum time in the field until the data saturation is achieved (Brink et al., 2018: 158). This is an opportunity for the researcher to gain an in-depth understanding of the phenomenon being

studied, which in this study was the birthing process preparedness of first-time mothers in the obstetric units of the NMBHD (Brink et al., 2018: 158). The researcher therefore ensured that interviews were given maximum time while gathering quality data until data saturation was achieved.

A ‘Do not disturb’ sign was displayed at the door of the room where interviews took place to avoid disturbance and to enable participants to be at ease during interviews. This environment is ideal to enhance trust and rapport between researcher and participant, which is a cornerstone when one needs to obtain rich data (Brink et al*.,* 2018: 158). The researcher made use of a voice-recorder to capture interviews (Brink et al*.*, 2018: 135).

Semi-structured interviews with open-ended questions were posed to the participants; but, at the same time, the researcher probed and explored for additional data (Gray et al*.,* 2017: 259). This action allowed for participants to express themselves fully, while at the same time allowing the researcher to gain an in-depth understanding of birthing process preparedness of first-time mothers. Interviews were to take a maximum of 40 minutes, which was noted to be adequate time to obtain sufficient data about the phenomenon at hand.

### *3.8.2 Transferability*

Transferability is referred to as the ability to use the research finding in other settings with similar participants (Grove et al*.*, 2015: 392). For the purpose of this study the following strategies were used to ensure transferability.

#### *3.8.2.1 Thick description*

According to Brink et al (2018: 159), thick description is the collection and provision of extensive description of research contents. For the purpose of this study the concepts and methodology used were explicitly clarified using relevant sources. The population of the study and sampling criteria were explicitly defined to ensure that findings solely reflected only the proposed context, which was the birthing process preparedness of first-time mothers in the obstetric units of NMBHD.

### *3.8.3 Dependability*

According to Grove et al. (2015: 392), dependability is the precise recording of steps and decisions taken during data analysis. Grove et al. (2015: 392) further highlight the process as an audit trail. In this study the following strategy was used to uphold dependability:

#### *3.8.3.1 Enquiry audits*

According to Brink et al. (2018: 159), inquiry audits allow the examination of documents of the critical incidents and process of data collection. In this study, the research proposal with a description of methodology, data collection and data analysis was given to the research supervisor to satisfy enquiry audits (Brink et al., 2018: 159).

### *3.8.4 Confirmability*

According to Grove et al. (2015: 392), confirmability is concerned with the authenticity of data which is investigated when other researchers review an audit trail and can agree that the conclusions arrived at are indeed logical. Furthermore, Grove et al. (2015: 392) maintain that, when study findings are confirmable and dependable, the study has more credibility. For the purpose of this study the researcher used an independent coder to verify and code the data to ensure that the data was free from researcher biases and that the data was a true reflection of information provided by the participants (Brink et al., 2018: 159).

## 3.9 Ethical research considerations

Ethical issues arise in the context of health research when it comes to collecting, storing and using individual data although Polit and Beck (2018: 77) highlight a concern about a grey area between what constitutes the expected practice of nursing and data collection in order to adhere to the principle of human rights. To satisfy the demands of this principle the Belmont Report was adopted in this study (United States national commission for protection of human subjects of biomedical and behavioural research, 1979). The researcher maintained the ethical strategies that uphold these principles as prescribed by the Belmont Report, discussed in sub-sections below.

In addition, although all information shared was treated with strictest confidence, the researcher felt that complete anonymity was impossible with the proposed study (Grove et al., 2015: 107). It remained, however, the researcher's responsibility to keep information provided strictly confidential under lock and key, for analysis, verification and publication and to ensure that such information was accessible only to the researcher and supervisor for five years after which it would be destroyed. The researcher was bound not to reveal personal information such as names, contact numbers and addresses.

### *3.9.1 Respect for persons*

According to Joubert and Ehrlich (2012: 32), respect for persons supports the principle of autonomy. Brink et al. (2018: 29) define autonomy as freedom to do and decide whatever the person wants, provided that such a decision does not infringe on the autonomy of others which means that detailed information had to be given to the participants to enable them to arrive to a decision to participate or not. Informed consent for voluntary participation in the study and permission was sought from first-time mothers meeting the inclusion criteria (Brink et al*.,* 2018: 32) and letters served to participants (annexure A) detailing the interview location and venue, the process, possible risk factors and interventions, possible benefits and rights of the participant.

Because interviews were to form part of discharge plan; the first-time mothers were given five hours after being recruited for the study and given detailed consent form (annexure B). In cases where it was impossible, the interview would be scheduled for the date and venue convenient for the woman or a date for a postnatal visit at a local clinic, which is accepted to be three to six days post-delivery (DoH, 2016: 136). Participants were asked to sign endorsement of their permission to participate in the study because a consent form highlights voluntary participation, assurance to withdraw at any time the participant wants, that the information will be treated with confidence and that the names will not be identifiable and/or used in any written reports (Joubert & Ehrlich, 2012: 35).

### *3.9.2 Beneficence and non-maleficence*

The essence of the principles of beneficence and non-maleficence is the duty of a researcher to promote good and not cause emotional, psychological or spiritual harm to a participant's dignity (Brink et al., 2018: 29). The researcher conducted interviews in a calm and non-judgemental way, being careful not to ask for information that would trigger a participant's unfavourable emotions and embarrassment. In anticipation of unfavourable emotions being triggered the researcher had previously arranged with a professional psychologist to be available always for professional counselling, the costs of which had to be met by the researcher; and furthermore, in such cases those interviews were to be terminated and the participant replaced. Annexure C and D were for the purpose of seeking permission from health authorities and subsequently to have access to relevant data (Joubert & Ehrlich, 2012: 35). The data collected was treated confidentially and kept in a password-protected computer and the identity of participants and institutions were kept private by withholding the true names and using pseudonyms for identification (Joubert & Ehrlich, 2012: 36).

### *3.9.3 Justice*

Justice is believed to be fairness in distribution of what is deserved (Joubert & Ehrlich, 2012: 33). For the purpose of this study the researcher followed convenience, non-probability sampling, excluding no participant based on their race, social or economic standing. Regarding access and use of maternity or medical care services, (annexure A) confirmed that such care would not be withdrawn because the woman declined and/or or had withdrawn from participation. The participants were assured that they would continue to receive the best of care due to them regardless of their choice of participation in the study. As long as the participant was believed to meet the criteria she would be sampled; there was no coercing of participants into participating in the study either.

## 3.10 Conclusion

The study employed a qualitative design with exploratory, descriptive and contextual approach. Since the aim of the study was to understand the birthing process

preparedness of first-time mothers in the NMBHD public obstetric units the findings of the research study would reveal an indication of their readiness for their birthing process. This chapter described the research design and methodology used in this study and the sampling, data collection, data analysis, trustworthiness of the study and the ethical considerations were comprehensively discussed. The next chapter will deal with data analysis and presentation of findings.

# CHAPTER 4

# DATA ANALYSIS AND PRESENTATION OF FINDINGS

## 4.1 Introduction

The previous chapter presented the research design and methods used in this study. The data was collected from first-time mothers who had given birth in public obstetric units in the NMBD. To understand their birthing process preparedness and provide an indication of their readiness for their first-time birthing process. This chapter focuses on presenting the data analysis and findings of this study.

## 4.2 Operationalisation of the study

The study was conducted in the public obstetric units of the NMBHD. The objectives of the study were to:

- explore and describe the birthing process preparedness of first-time mothers in the public obstetric units of the NMBHD and
- formulate recommendations for the midwives and nurse managers that would aid them in facilitating the readiness of first-time mothers for the birthing process in public obstetric units in the NMBHD.

This study utilised a qualitative research design with exploratory, descriptive and contextual approach to gain an in-depth understanding of the birthing process preparedness of first-time mothers in the NMBHD public obstetric units. The sites were accessed following gaining the necessary permission from the Department of Health and specific public obstetric units in the NMBHD. The managers in those sites were used as gatekeepers. Convenience and non-probability sampling were used in selecting participants who met the set of inclusion criteria for the study.

Data was collected by means of semi-structured Interviews that were captured using a digital audio-recorder. Semi-structured interviews allowed the participants to reflect on their preparedness for their birthing process.

The total of sixteen first-time mothers who had delivered in the public obstetrics units in the NMBHD were interviewed by the researcher; but one interview was eliminated as it was found during the interview that the participant was a high-risk case and had to be excluded. The excluded participant was informed upon completion that her interview will not be part of the study, but that the information given by her would be kept safe by the researcher.

Languages used during the interview sessions were English and isiXhosa as those were the languages with which the researcher was familiar and comfortable to use. Although mainly English was used, some of the participants opted for isiXhosa which they were allowed to use. The majority of the interviews took place in an unoccupied kitchen while a few took place in the other wing of the manager's office inside the public obstetric unit. These places were anticipated to have minimal disruption but assurance of privacy of the participant as well. Of the sixteen interviews one interview was conducted at participant's home for the benefit of minimal disruption and noise as preferred by the participant and the majority of the participants had their babies with them during the interviews. Bonding, feeding and nappy changes were encouraged by the researcher during this stage. This period provided an ideal opportunity for the researcher to correct uncertain behaviours and techniques about feeding and cord care practice amongst the first-time mothers.

During the interviews the participants were allowed time to express themselves and tell the story of their experiences regarding birth preparedness as a first-time mother without the feeling of being rushed into talking. All this time the researcher would be listening attentively as the interview was being captured on a voice-recorder. Eye contact with the participant was maintained so as to observe non-verbal communication of the participant and explore responses further to ensure a thick description of the experiences being told. Participants responded to the following main question:

*"Can you tell me how ready you were, for your birthing process?"*

Depending on the responses to the main question by the participants, the researcher also used some questions from the interview schedule and probing questions. The questions used for probing responses were, for example:

- *Can you tell me more about your birthing process readiness?*
- *Can you elaborate on your response?*
- *Can you confirm if I understand your response correctly?*

Field notes were also jotted down to capture mannerisms and moments impossible to be captured through recording and because they might be adding valuable data to the study. The recordings were transcribed verbatim by the researcher soon after each interview. The interviews were easy to manage as the participants were sharing information willingly. When data saturation guided the end of data collection analysis of it could commence.

Data analysis is the process of interpreting collected data by reducing and organising it to give it explicit meaning (Grove et al*.,* 2017: 47). Since the data analysis in qualitative research studies is done simultaneously with data collection (Grove et al*.,* 2017: 88) the recorded interviews were transcribed verbatim one-by-one as soon as possible. Transcripts were stored individually while maintaining proper identification of each transcript to ensure privacy and confidentiality of the participants. Field notes written during the interview session were useful in creation of meaning of each interview. The data generated after each interview was analysed using the thematic method of data analysis.

Familiar trends and statements of all interviews were aligned and grouped together to formalize data analysis which was done by the researcher while the services of an independent coder using the thematic method of data analysis were used (See Harvey & Land, 2017: 284). The researcher and the independent coder had a consensus meeting virtually to agree on the themes and a meeting between researcher and supervisor was held to agree on the final themes that had emerged. Themes that emerged from the data analysis are discussed in chapter five. The research results revealed the demographic profile of the participants as depicted in Table 4.1 below.

**Table 4.1: Demographic profile of participants**

| Pseudonym | Age | Ethnic group | Religion | Highest level of education | Occupation | Gestational age at birth |
|---|---|---|---|---|---|---|
| Miss A | 18 | Coloured | Christian | Grade 08 | Scholar | 37 |
| Miss B | 18 | African | Christian | Grade 11 | Scholar | 36 |
| Miss C | 30 | African | Christian | Diploma | Facilitator | 39 |
| Miss D | 21 | African | None | Grade 12 | Learner | 36 |
| Miss E | 20 | African | Christian | Grade 11 | None | 38 |
| Miss F | 21 | African | Christian | Grade 10 | Scholar | 36 |
| Miss G | 30 | African | Christian | Diploma | None | 38 |
| Miss H | 18 | African | Christian | Grade 11 | Scholar | 41 |
| Miss I | 22 | African | Christian | Grade 12 | Waiter | 36 |
| Miss J | 18 | African | Christian | Grade 12 | Learner | 40 |
| Miss K | 18 | African | Christian | Grade 11 | Scholar | 41 |
| Miss L | 19 | African | Christian | Grade 12 | Learner | 39 |
| Miss N | 22 | Coloured | Christian | Grade 11 | Machine operator | 37 |
| Miss O | 25 | African | Christian | Grade 12 | Administration clerk | 37 |
| Miss M | 23 | African | Christian | Grade 12 | Learner | 39 |

The profile assisted the researcher with some information that might be needed should there be some related questions asked by participants for future care of the baby.

The most helpful information was especially in the areas of occupation against gestational age for maternity leave and potential harmful exposure to the pregnancy. None of these areas posed a risk to the participants.

The above table portrays the participants' ages being between 18-30 years. In terms of age the researcher expected understanding of the birthing process to be directly proportional to the increase of age of the participants. The older participants may possibly have had more opportunities to interact and converse with numbers of experienced people and sources compared to the teenagers, which in turn would place them in an advantageous position of better understanding of birthing process. Again, another assumption was that new mothers overall may have had wider opportunities to enhance their birthing process preparedness through utilisation of contemporary technology and applications which means that most first-time mothers who participated in this study may have been exposed to the birthing process or some degree of birthing process preparedness. There was no observable significance of age in this study.

The majority (87%) of participants were of African ethnicity while the remaining minority were of coloured ethnicity. In this study no significance associated with ethnicity emerged. All participants had completed a preliminary educational level. The majority (60%) of them were still at school, either scholar or learner: 13% of participants had completed a diploma as their highest qualification while the majority (40%) had completed grade 12 as the highest qualification. Although an assumption is that better understanding of the birthing process is directly proportional to the level of education of a concerned woman, in this study the position of highest level of education did not appear to have influenced the findings as the birthing process had been viewed as an overwhelming process by most of the participants.

The majority of participants had given birth at term gestation (37- 41 weeks) at the time of their birthing process. By virtue of gestational age, all participants were expected to have been exposed to ANC several times and therefore exposed to current practices of birthing process preparation. In this study no difference was noted amongst the participants with regard to birthing process preparation, based on their gestational age. 7% of participants did not state their religion, while the majority (93%) of participants stated that they were Christians.

Participants were expected to rely on and/or refer to their religion with regard to birthing process preparation and during the birthing process; but in this study no major observable significance was noted to have been as a result of religion.

### 4.3 Identified themes

A theme is defined as a broad unit of information that contains several codes combined to form a common idea (Creswell, 2014: 136). The main themes and sub-themes that emerged are shown in Table 4.2 below:

**Table 4.2 Identified themes and subthemes related to birthing process preparedness of first-time mothers**

| **Main themes** | **Sub-themes** |
|---|---|
| 1. Participants shared their experiences regarding their birthing process and their birthing process preparedness. | **Participants experienced:**<br>1.1 fears associated with their birthing process and<br>1.2 feeling mainly unprepared for their birthing process. |
| 2. Participants expressed having had varied experiences from factors that had influenced their birthing process preparedness. | **Participants expressed:**<br>2.1 limited information shared by midwives regarding their birthing process,<br>2.2 ineffectiveness of pain relief strategies and<br>2.3 birthing process preparation had been received from varied sources. |

| | |
|---|---|
| 3. Participants provided suggestions for midwives to facilitate their birthing process preparedness | **Participants suggested:**<br>3.1 birthing process preparation classes,<br>3.2 birthing process preparation through counselling sessions and<br>3.3 detailed information mainly about the birthing process. |

The themes in this study reflect the experiences voiced by the first-time mothers during their face-to-face interviews, regarding their preparedness for their birthing process. The broad information in this study that emerged from the data collected and analysis was that the participants were fearful of their birthing process. Such fear was found to be the result of the lack of the birthing process knowledge. Participants were fearful of the actual birthing process, necessary birthing procedures such as digital vaginal examination and fetal monitoring through CTG, unfavourable outcomes such as losing the baby as well as birthing process pains. Of note was that participants in this study acknowledged having expected a painful birthing process, however, to a lesser extent compared to the actual lived experiences of their birthing pains. In this regard, participants voiced being frustrated and wishing for the birthing process to have been of shorter duration. Nonetheless, some participants in this study appear to have associated cumulative birthing pains with the progress of their birthing process; yet other participants had questioned the cumulative birthing process pains from their midwives.

Participants overall felt unprepared for their birthing process, mainly owing to the limited information having been shared by midwives. In this regard, participants were unaware of some of the birthing process inevitabilities such as procedures necessary during the birthing process. For example, participants had not received sufficient information on signs of the imminent birthing process, such as presence of a show; it also seemed that there was limited information on duration of birthing pains; and that these women did not expect that there would be recurrent vaginal examinations to assess their progress of labour. The participants also voiced ineffectiveness of pain relief strategies which were mainly non-pharmacological as well as pharmacological.

Participants in this study acknowledged having received birthing process preparation from varied sources in addition to midwives. For example, participants quoted these sources as being family members, friends, Mom-connect and the Internet. This study found that women with experience of the birthing process were resourceful in coaching first-time mothers. Participants also mentioned using the Internet as reference to enhance their understanding of their birthing process preparation where there was observed to be a knowledge gap regarding the birthing process. Furthermore, some participants had used social media such as Facebook, YouTube and Mom-connect services to contribute to their birthing process preparedness while their perception of the role of midwives was that of a professional nature as in attending to maternal and fetal wellbeing.

Lastly, participants provided suggestions for midwives to facilitate their birthing process preparedness. Those recommendations were that birthing process preparation classes as well as birthing process preparation counselling sessions would be helpful and more detailed information about what to expect during the birthing process.

## 4.4 Conclusion

This chapter presented the data analysis adopted in this study, including data analysis methods and final findings of this study. The aim of the study was to understand the birthing process preparedness of first-time mothers in the public obstetric units of the NMBHD. Data saturation was reached after fifteen recorded face-to-face interviews had been held. Data coding process was conducted using the thematic method of data analysis. Three main themes and eight related sub-themes emanated from the data collected. The next chapter will therefore focus on the discussion of those findings.

# CHAPTER 5

# DISCUSSION OF FINDINGS

## 5.1 Introduction

In the previous chapter there is a presentation of the data analysis method and findings of this study from the information obtained during the fifteen interviews conducted. This chapter will thus focus on the discussion of those findings. Existing and related literature was used to confirm or challenge those findings as means of creating meaning to the stories told by the participants. The findings reflect the diverse experiences of first-time mothers in the NMBHD public obstetric units regarding their birthing process preparedness. Three main themes and eight related sub-themes emerged from the data analysis. A summary of the findings of the study is presented in table 5.1 below which is followed by the discussion section of those findings.

**TABLE 5.1 Identified themes and sub-themes related to birthing process preparedness of first-time mothers**

| **Main themes** | **Sub-themes** |
|---|---|
| 1. Participants shared their experiences regarding the birthing process and their birthing process preparedness. | **Participants experienced:**<br>1.1 fears associated with their birthing process and<br>1.2 feeling mainly unprepared for their birthing process. |
| 2 Participants expressed having had varied experiences from factors that had influenced their birthing process preparedness. | **Participants expressed:**<br>2.1 limited information shared by midwives regarding their birthing process, |

| | |
|---|---|
| | 2.2 ineffectiveness of pain relief strategies and<br><br>2.3 birthing process preparation received from varied sources. |
| 3. Participants provided suggestions for midwives to facilitate their birthing process preparedness | **<u>Participants suggested that midwives provide:</u>**<br><br>3.1 birthing process preparation classes,<br><br>3.2 birthing process preparation counselling sessions and<br><br>3.3 detailed information mainly about the birthing process. |

## 5.2 Discussion of findings

Below is the discussion of theme one and its related sub-themes. To facilitate a better understanding of the discussion the researcher will from now onwards refer to first-time mothers that took part in the study as participants unless the need arises to address them otherwise**.**

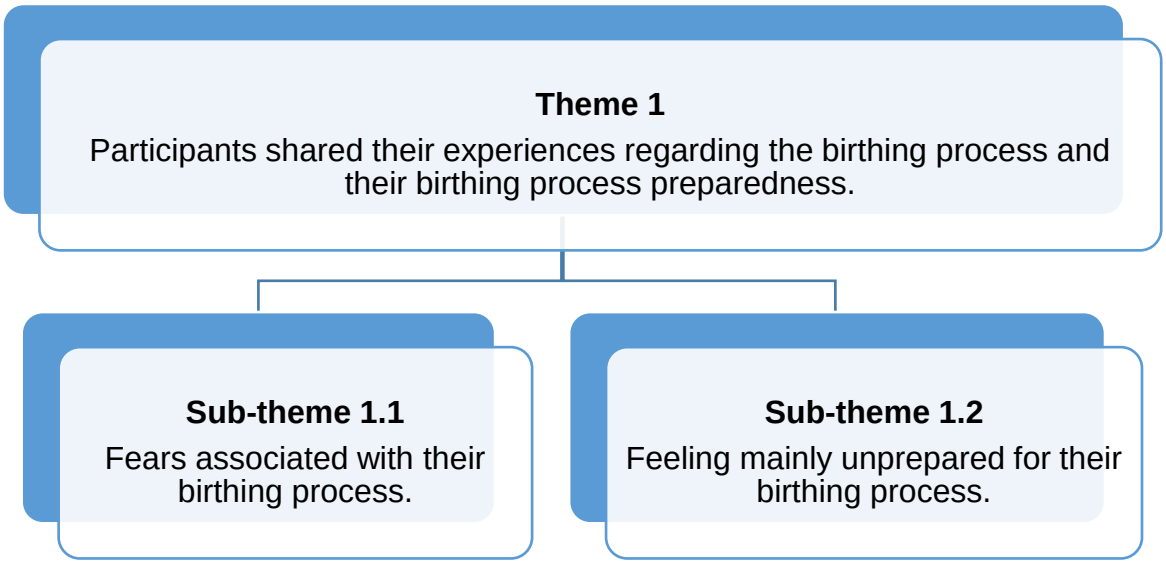



**Figure 5.1: A diagrammatical representation of theme one and related sub-themes.**

### *5.2.1 Theme 1: Participants shared their experiences regarding the birthing process and their birthing process preparedness.*

The birthing process of the first-time mothers is a phenomenon that still needs some exploration since not much has been discussed about it. As such, Nilsson et al. (2013: 1) maintain that women's birthing experiences have been ignored and the focus has been merely on their obstetrical outcomes. In this study participants shared personal experiences applicable to their birthing process preparedness and it was observed how freely these experiences were shared, moreover, the extent of the relief following that sharing. The participants shared these experiences from different perspectives and in many ways. Some of the participants had experienced birthing as a painful process which they said had been exacerbated because of cumulative birthing pains and other associated unavoidable procedures conducted during their birthing process. Some of the unavoidable procedures referred to were digital vaginal examinations and fetal monitoring using cardiotocography (CTG) machine. For instance, one participant in this regard had the following to say:

**"…*eleke efaka umnwe wakhe unesi bekungathi ku worse kunakuqala angathi uwufaka deep ngoku, angathi ngaske ayeke. Kwayile yala machine athi uva intliziyo ububa worse qho. Xa ekubizela kula machine bekungaske ungayi. Ubawela ukuwujikisa, ubawela ukuwijisa, nyhani*"** *(…each time midwife was inserting fingers, it would feel like it is worse than the first time as if **[fingers]** are inserted deep now, the wish was that the midwife could just stop **[digital vaginal examination].** Even that machine **[CTG]** for the heartbeat, each time you are put there it feels like it is worse than before. Each time you are called for that machine **[CTG]** you would feel like not going. You want to turn it away, you want to turn it away, seriously).*

(P7, L382-390)

The interview sessions were seen to have provided some of the participants with the opportunity to voice the nature of their first-time birthing process preparedness and birthing process experiences. Some participants expressed that they were unprepared for their birthing process which caused a lot of fear in them while the others felt that, though the preparation had been done it was not sufficient. In this regard Namujju et al. (2018: 2) state that the birthing experience depends on women's personal feelings and interpretations associated with the birthing process. The predominant feelings expressed about the birthing process experiences were associated primarily with the fear of the birthing process. One participant said:

***"… bendisoyika because bendingayazi lento bendiyi experienca ngelaxesha, bendicinga mhlawmbi kukho lonto yenzekayo imbi, uyabona? emntaneni okanye like ndizo loose umntana since bendibona igazi, so bendisoyika kakhulu*."** (…*I was scared because I didn't know what I was experiencing at that time, I thought there is something bad you see? happening in the baby **[fetus]** or like maybe I will have miscarriage since I was seeing blood, so I was very scared.)*

(P12, L73-75)

The depth of experiences shared by the participants which is theme one of this study will be discussed below under the following sub-theme headings:

- Fears associated with their birthing process
- Feeling mainly unprepared for their birthing process

*5.2.1.1 Sub-theme 1.1: Fears associated with their birthing process.*

According to Wehmeier, McIntosh, Turnbull and Ashby (2006: 538), fear is defined as an unpleasant emotion as a result of any related threat or danger. In the context of this study, because participants viewed the birthing process, the procedures associated with the birthing process and anticipated unfavourable outcomes as threats, they were fearful. The predominant fear voiced by many of the participants was being fearful of numerous aspects associated with the birthing process, such as the actual birthing process, pains associated with the birthing process and the possible unfavourable outcome such as losing the unborn baby. The experiences regarding fears associated with the birthing process were expressed as follows:

***"bendisoyika, ndikhala nokukhala because andiyazi lento anhe! But then ndifike apha esbhedlela bandixelela bathi akukhonto iwrongo ngam, ndiright. So mandi relaxe ndibreathe so that ndinga ...istress [baby crying] kakhulu [uxolo sisi {Comforting the baby}]."*** *(I was scared, crying because I did not know this thing* ***[birthing process]*** *nhe! But then … when I got there in the hospital, I was told that there is nothing wrong about me, I should relax and breath so that I do not … the stress* ***[baby crying]*** *a lot* ***[sorry sisi {Comforting the baby}])***

(P12, L140-143)

*"You are scared to toilet* ***[empty your bowel]****. You do not know whether the baby will come out or not. You are just not sure, and they* ***[midwives]*** *keep saying, when you feel pain, push."*

*(P3, L512-515)*

The latter responses illustrate the fear of the birthing process as a result of lack of knowledge of how it would unfold as it proceeded. Consequently, one participant acknowledged being reassured at the obstetric unit, regarding normality of the occurrences of the birthing process and responded positively after being told about the appropriate expected response such as breathing exercises.

The fear of the birthing process seems to be a shared phenomenon among birthing women, regardless of their parity (Rondung, Thomten & Sundin, 2016: 83). The fear about birthing process experiences reported by the participants in this study is said to

have implications such as postpartum mental health problems (Slade, Balling, Sheen & Houghton, 2019: 2). Moreover, Aksoy, Aksoy, Dostbil, Celik and Ince (2014: 1); Slade et al. (2019: 2) attest that fear of the birthing process is a serious problem for women and is associated with the poor progress of labour and further associated with fear of falling pregnant again. This unfortunately leads, amongst other issues, to increased requests for caesarean section in subsequent birthing (Slade et al., 2019: 2). It appears therefore that fear of the birthing process overall may have long-lasting implications for birthing women regardless of their parity, if the current one is not correctly dealt with during birthing process preparation.

Some of the participants in this study were fearful of unfavourable birthing process outcomes as these are almost inevitable while others voiced being fearful of losing their unborn babies during the birthing process, as was said by one participant.

***"Intliziyo yam ibibuhlungu coz [bendicinga] if ndinokum loosa lomntana ndingayithini loo nto? Kuba ndiyamfuna."*** *(My heart was aching; I* ***[thought]*** *what if I would lose this baby, how would I deal with that? Because I want it* ***[the baby]****)*

(P7, L480-481)

The latter response demonstrates the fear of the possibility of an unfavourable birthing outcome, such as giving birth to a stillborn. Sengane (2013: 1) attests that pregnant woman often expect positive birthing outcomes and it could be assumed that this experience shared above was from that expectation but owing to fear also the lack of mental preparation in case of a different outcome. In view of this experience, Slade et al. (2019: 7) reiterate, in establishing a valid construct of fear of childbirth, that labouring women are fearful of potential physical harm or death of a baby. Similarly, in a study done among Iranian women about the role of fear of childbirth, it was found that the participants were concerned about childbirth complications such as possible injury to the woman or to their neonate (Arfaie, Nahidi, Simbar & Bakhtiary., 2017: 3738). All the above-stated findings of unfavourable birthing outcomes from feelings shared by women about their birthing process from different studies mentioned are therefore consistent with the findings of this study.

In their study about women's experiences of fear of childbirth Wigert, Nilsson, Dencker, Begley, Jangsten, Sparud-Lundin, Mollberg and Patel (2019: 7) found that

fear of the birthing process among first-time mothers was predominantly fear of the unknow and furthermore, assumed to be a consequence of lack of previous experience of the birthing process. Similarly, in this study the participants stated that they were not knowledgeable about what would happen during their birthing process. Among other aspects that were expressed as fear-provoking factors during the birthing process were pains associated with the birthing process. Sengane (2013:1), who supports this theory, observed that first-time mothers assumed that giving birth would be unbearable or that something would go wrong.

While pains during the birthing process seem to be inevitable, not all women experience such pain in the same way (Whitburn, Jones, Davey & Small, 2017: 2). With reference to this statement, James and Hudek (2017: 36) maintain in their study that, although labour pain is a universal feeling, the perception of that pain and response differs from woman to woman. Participants expressed their feelings regarding experiencing a painful birthing process as follows:

***"bendiyazi ukuba kuzobabuhlungu but I had to hang in there and I had to uba ndingaziniki istress because of umntana."*** *(I knew it will be painful but I had to hang in there and I had to take it so that I do not have stress for the sake of the baby).*

(P9, L65-66)

*"The first ones were like I have menstrual pains; it was like I am menstruating and these ones* ***[referring to birthing pains]****, I can't explain them because they were really painful. They were really painful; I really cannot explain them."*

(P5, L121-123)

Participants related the severity of pains associated with the birthing process with unpleasant emotions such as being frustrated, reporting that the pain from the birthing process was so severe that the duration of the labour seemed extended and left them frustrated. One participant in this regard responded as follows:

*"On the other side you are frustrated, you are feeling pains you wish for the whole process* ***[birthing process]*** *to finish and be done with it, you, see?"*

(P3, 538-539)

Such experiences as those stated above are congruent with those emanating from a study done by Siyoum and Mekonnen (2019: 1) where participants were stated as

viewing the birthing process pains as a unique and the most severe painful event in the women's lives. Such experiences were also expressed by participants of a study done in Nigeria, where women perceived birthing pains as severe (Akadri & Odelola, 2018: 1); therefore, it is evident that the birthing process is universally experienced as a severely painful phenomenon by birthing women. The results of this study are thus congruent with existing literature regarding birthing process preparedness and the birthing process as experienced by women and especially first-time mothers.

Even though the birthing process is experienced as severely painful, Whitburn et al. (2017: 4) found that women acknowledged the pain of the birthing process as productive and purposeful when it was associated with a desirable outcome, which is the birth of a live child. Similarly, in this study participants associated cumulating birthing pains with the progress of the birthing process and expressed it as follows:

*"Hence, I am saying when I got to ten **[centimetres of cervical dilatation]** I was shattered because I was already out of my mind **[due to pains]** … to me ten **[centimetres of cervical dilatation]** is the toughest stage, is the stage where the baby is really close **[imminent]**, you see?"*

(P7, L276-285)

*"I asked that nurse **[midwife who]** was helping me, what was happening, she said, '**now the baby is descending, you see that is why you are feeling more pains**. I could also see that my abdomen is flat here on top **[pointing]** and it moved to the bottom. Then she told me that it is the reason why I am in so much pain and my bones are opening up **[referring to the pelvis]**, that was what she told me."*

(P13, L327-333)

*"Hayi sana! When you get to that ten **[referring to cervical dilatation]** you already shattered. You can't even do a thing; you can't even sit. You don't even know if you should sit with buttocks on the bed. You don't even know if you should lie on your side, you don't know whether you should walk up and down. It becomes difficult."*

(P7, L251-256)

The responses provided above demonstrate that some of the participants could relate the culminating of contractions with the desirable progress of the birthing process which is the birth of the child, whereas other participants questioned the midwives

about the reason for the severity of contractions as they were observing the body's physiological responses brought about by the culminating birthing pains. The findings of this study appear to be consistent with those of a study done by Whitburn et al, (2017: 4), where women acknowledged the intensity of birthing pains as a positive sign of the progress of the birthing process. In this regard James and Hudek (2017: 37) believe that the pain associated with the birthing process is often an appealing experience because it is attached to a special sense of achievement that of the birth of the baby.

Some of the characteristics indicating good progress of the birthing process are dilatation and effacement of the cervix, consequently accompanied by pains. The dilatation and the effacement of the cervix are determined through the digital vaginal examination. Such an examination is performed by the insertion of index and middle finger of the midwife's hand, into a labouring woman's vaginal orifice to feel for the cervix to assess these two measurements. Even though digital vaginal examination is acknowledged to be the core procedure during the birthing process in making a clinical decision, it is also associated with adverse effects such as pain, discomfort and embarrassment (Hassan, Sundby, Husseini & Bjertness, 2012: 1). Participants also mentioned having reacted with unfavourable behaviour towards necessary birthing process procedures such as digital vaginal examinations and continuous fetal monitoring with the cardiotocography (CTG) in particular. Participants expressed their unfavourable response to necessary birthing process procedures as follows:

*"Mmh! It **[digital vaginal examination]** is annoying. It is annoying **[laughing]** because it feels like the more it **[fingers]** are inserted. Okay not the more, as it is inserted it feels like it causes the pain to be more, I don't know how. But that is how, I personally felt yesterday."*

(P8, L99-101)

*"But hey! As they **[the midwives]** are doing this, it **[the pain]** would feel like it is worse as the nurse **[midwife]** is inserting finger it would feel like it is worse than before…"*

(P7, L382-390)

*"And those machines **[referring to CTG]** are not a nice thing, it is like the labour becomes worse when you are put on the machine, that is why I did not want that machine"*

(P7, L554-556)

The participants confessed that the procedures followed by the midwives during the birthing process had caused unpleasant feelings such as pain and frustration and consequently seemed to have increased the birthing process pains. The findings of this study are consistent with the findings of the study done on Palestinian women regarding their experiences about the practice of vaginal examination during the birthing process. The results in that study revealed that most participants had reported the digital vaginal examination to be painful (82%) while some reported discomfort and embarrassment, 68% and 5%, respectively (Hassan et al*.,* 2012: 6). Furthermore, in their study Dixon and Foureur (2010: 24) reported that 42% of women had commented that digital vaginal examination was painful and distressing but felt compelled to endure this procedure; therefore, it is apparent that inevitable birthing procedures such as digital vaginal examinations and CTG monitoring are associated with pain.

Although these procedures are observed to be painful by many labouring women, participants in this study demonstrated insight regarding why the CTG monitoring was used during the birthing process and expressed their insight as follows:

***"Ndiye ndayazi apha [esibhedlela] uba xa kufakwa lamabhanti [CTG] kujongwa umntana wam. Kulapho, ngoku bendifakwe lamabhanti [CTG] kwabhaqeka izinto ebendizitya zonke, uba bendisitya izinto ezingekho right zabonwa pha kulanto bendiyenziwa yalamabhanti [CTG]…umchamo wemfene, ezizinto zesintu, lamayeza wesixhosa, ndibhaqwe pha, uba bendike ndazitya."*** *(I only knew about them **[referring to CTG belts]** here **[at the hospital]**, that they are assessing my baby. The belts **[referring to CTG]** I also discovered of all the things I had been eating, things that aren't alright… umchamo wemfene the **Xhosa traditional medicine** was discovered there **[by the CTG]** that I had taken them).*

(P6, L261-268)

*"Umh! that machine **[referring to CTG]**, that one making the sound. Yho! It is one of the things that is frustrating me, because while you have hurting pain here **[pointing***

***to abdomen]*** *and then you have to wait for that machine that it reads through the heartbeat of the baby and it needs to be a little bit long."*

(P3, L492-496)

***"Yho hay! indiphambanisile [iCTG] because uthi ulunywa kufuneke ulindele lento [CTG] until ide igqibe ukwenza laa process yayo iyenzayo, yokuva iiheartbeat zomntana, nazo zonke ezazinto, uyabona? … ibuhlungu."*** *(Yho hay! it* ***[the CTG]*** *made me to lose my mind because you are having labour pains and you should wait for it* ***[CTG]*** *to finish its process of recording heartbeats and all those things you, see? … It is painful).*

(P10, L256-260)

While participants said they had experienced the CTG monitoring as painful they acknowledged its vital necessity to confirm the well-being of the baby and thus the need to cooperate regardless of the associated pain and discomfort. In their systematic review Crawford, Hayes and Johnstone (2017: 1408) found that women indicated that the audible fetal heartbeat had been reassuring to them and thus demonstrated positive perception regarding the use of CTG. In this study participants perceived CTG monitoring as a painful procedure; but they were insightful of the fact that it ascertained fetal heartbeat and thus the need for them to cooperate. Interestingly also, participants were of the view that CTG monitoring determined if traditional medication had been taken during pregnancy and other harmful diets they had followed during their pregnancy. To this effect, though some of the participants had some other distorted information about procedures and equipment used it was apparent that they acknowledged the positive significance of the CTG monitoring procedure during their birthing process.

#### *5.2.1.2 Sub-theme 1.2: Feeling mainly unprepared for their birthing process.*

The participants shared their experiences regarding how prepared they were for their first birthing process. In retrospect, some commented that even though initially they had thought they were prepared for the birthing process realised later that they were not completely prepared when the birthing occurred. In this regard participants had the following to say:

*"I wasn't mostly prepared but my mother told me what is going to happen **[and]** what I must do."*

(P3, L17-18)

*"umh! I think I was well prepared, cause at the clinic when I was there for the first time … I think I was four – five months then I was told what to expect, you see during the pregnancy."*

(P14, L17-18)

***"Ha-a! khange indi preparishe tu! iclinic, coz ezinye izinto ndizive apha mna."*** *(Ha-a! **[No]** the clinic did not prepare me at all because I was introduced to other things only when I was here **[in the labour ward]).***

(P8, L27-28)

Birthing preparedness experience is multidimensional, subjective and depends on the individual woman's experience (Mutabazi & Brysiewics, 2021: 1). According to Wehmeier et al. (2006: 512), experience is observed to be the knowledge and skill that is acquired through exposure for some time. Considering the stated definition, because the participants in this study had no existing experience of the birthing process. They were therefore being exposed for the first time to an array of unforeseen possibilities regarding birthing process and subsequently formulating their birthing process experience, hence the difference in each one's experience. Some of the participants seemed to acknowledge that attending ANC clinics had played a role in their birthing process preparation and expressed it as follows:

*"I think it **[birthing process preparation]** had a big role in my pregnancy because I didn't know most of the staff **[things related to the birthing process]** that they **[the midwives]** taught me there regarding the baby **[referring to the fetus]."***

(P15, L196-197)

*"…**[birthing preparations]** were alright because I didn't know about them, nhe! I don't **[did not]** know anything about pregnancy, so it was alright they **[the midwives]** had tried, tried to explain about pregnancy **[in order]** to understand signs and things that*

*are happening **[during]** the pregnancy, experiences that a person would have, during the pregnancy*."

(P12, L95-99)

*"It **[birthing process preparation]** was a good quality and on their side they **[the midwives]** are trying to give out the information like that, usually on Fridays they do not take appointments for antenatal check-ups, because they **[the midwives]** are having those sessions."*

*(*P9, L157-160)

The responses provided illustrate the acknowledgement of the role of birthing process preparation and the participants' realisation that birthing process preparation had provided them with the information needed in pregnancy. In a study about the timing and quality of antenatal care received by women in Peru, women perceived attending an ANC clinic as vital as it provided them with pregnancy-related health information (Wynne, Duarte, de Wildt, Meza & Merriel, 2020: 12). The findings of the above-mentioned study are therefore consistent with the findings of this study as the participants in both studies acknowledged the role of ANC in preparing for a positive birthing process. Contrary to the results of the above studies, it happens at times that the information shared during ANC is not helpful depending on how it was received. For example, results of a study that was conducted in Gambia about women's perception of antenatal care services in public and private clinics, women (80%) reported having received inadequate information on pregnancy issues, thus, not told how to recognise or manage danger signs during pregnancy (Jallow, Chou, Liu & Huang 2012: 597).

Monitoring during ANC is expected to include advice to women about care during pregnancy and what to expect during labour and birth (WHO, 2015: 14-15). The participants expressed concern that they had not been completely ready for the birthing process since they did not comprehend totally the information shared by midwives? during ANC and consequently did not know how to respond to the event. Participants expressed emotions such as shock and surprise at the events that had occurred during the birthing process. Experiences were expressed as follows:

*“I was not fully prepared, nhe! because I didn’t know other things. Like for instance I came here … oh! at the clinic they **[the midwives]** are telling us things nhe! like danger signs and things when you close to give birth. Then with regard to birthing process preparation they **[the midwives]** were not more specific about it. Because I didn’t know like when there was that jelly **[mucus show]** that was coming out I didn’t know what did it mean, you see. So, I was not prepared enough.”*

(P13, L17-24)

*“Cause there was just a lot of things I was shocked about, there **[labour ward]**. Like as I had said that I was expecting just pain and then to give birth, there is just a lot that … and that breaking of waters. That process of breaking of waters, I just thought it will just be little water and then I would go through all that.”*

(P14, L65-69)

***“Mhi-mhi bendingekho prepared. Kundothusile nokukwam cause bendina 36 weeks. So kwakuthiwe kum, [ndizobeleka] kwi 40 weeks. Then bendibekelwe ne date ba ndize ndiphinde ndibuyele eclinic, ndothuswe kukuba kufuneke ndize apha esbhedlela”** (Mhi-mhi **[meaning no]** I was not prepared. It **[birthing]** surprised me too because I was 36 weeks. They **[the midwives]** said to me at 40 weeks **[due to give birth]** I was even given a date to come back to the clinic, so I was surprised by the fact that I had to come here at the hospital **[labour ward]**).*

(P6, L16-20)

Participants had discovered other unfamiliar aspects of the birth process as the birthing was unfolding and were shocked when these unfamiliar aspects took place. The findings of the study done by Munkhondya et al. (2020: 308) about childbirth fear and preparation among primigravid women confirm that primigravid women who experienced labour with inadequate childbirth preparation were exposed to shortcomings during the birthing process. Consequently, owing to the demonstrated shock response this ill-preparation and ignorance caused, the primigravid women were then blamed by their carers during labour (Munkhondya, et al., 2020: 208). This corroborates the statement that poor understanding of the birthing process subjects primigravid women to shortcomings during their birthing process.

Although the lack of understanding of the birthing process is associated with the ignorance of expectant mothers, there are other factors that should be considered as well as causative factors. The next theme elaborates on the experiences from other factors that influence birthing process preparedness.

### *5.2.2 Theme 2: Participants expressed having had varied experiences from factors that had influenced their birthing preparedness*

The participants in this study acknowledged that there were factors that had influenced their birthing process preparedness either positively or negatively. The concept 'influence', according to Wehmeier et al. (2006: 765), is any factor which has an effect on something or on the character of someone. In the context of this study the influence was on the preparation of first-time mothers for their birthing process. The participants expressed having had mixed feelings about the way they had been prepared for their birthing process, such as limited information being shared by the midwives regarding their birthing process and ineffectiveness of pain relief strategies used during the birthing process. The mixed feelings were exacerbated by the fact that participants had consulted varied sources for their birthing process preparation which had probably led to confusion. The sources consulted were of formal and informal nature. While influencing birthing preparedness in a positive manner could contribute to maternal satisfaction of the birthing experience, factors influencing birthing preparation in a negative manner would have had an unconstructive impact on subsequent birthing choices of the woman (Smarandache, Kim, Bohr & Tamim, 2016: 1). For example, a birthing woman may opt for caesarean section in subsequent pregnancies because of factors which influenced a previous vaginal birthing process in a negative manner (Smarandache et al., 2016: 2; James & Hudek, 2017: 36).

Below is the discussion of the factors that influenced the birthing process preparedness of the participants, namely,

- limited information shared by the midwives regarding their birthing process,
- ineffectiveness of pain relief strategies and
- birthing process preparation received from varied sources

Figure 5.2 below presents a summary of theme two and sub-themes that will now be discussed.

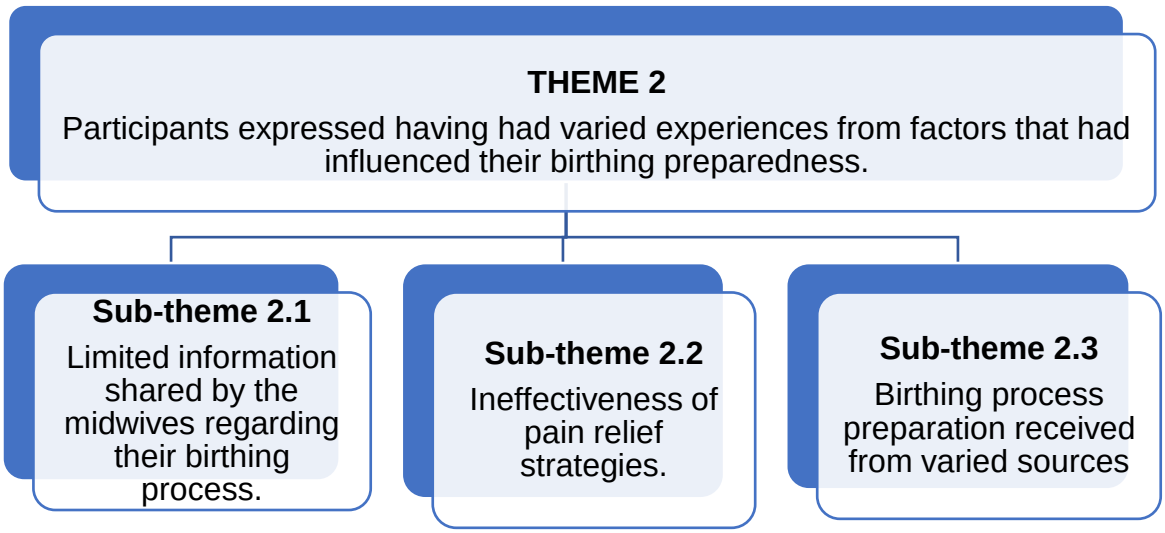



**Figure 5.2: A diagrammatical representation of theme two and related sub-themes.**

*5.2.2.1 Sub-theme 2.1: Limited information shared by the midwives regarding their birthing process.*

Information sharing is an important component in any healthcare environment to facilitate cooperation and understanding of actions taken by all those involved. Communication allows for evaluation of the effects of any actions implemented for the sake of treatment and care delivered to a patient or a birthing woman in the context of this study. In this regard the South African national Department of Health maintains that the provision of information to pregnant women remains the area of emphasis (DoH, 2016: 29). Information refers to facts or details about an unknown phenomenon (Wehmeier et al., 2006: 765). Cognisance of this definition and the background presented could thus suggest that lack of facts or details about a specific phenomenon could have led to concerns among the participants about the inadequate information shared by midwives regarding their birthing process. Birthing process information is observed to be crucial because it enhances acceptable health behaviour, self-care and empowerment for birthing women (Javanmardi et al., 2019: 1). This relates to a study about birthing process preparedness which was conducted in Malawi in which participants had voiced a feeling of being uncomfortable to give birth as a result of

unclear and inadequate information they had received during their birthing process preparation (Munkhondya et al., 2020:308). In this regard it would be safe to say that birthing information provided at ANC clinic visits and during labour assists with positive preparedness for the birthing process, especially for first-time mothers and as preparation for future pregnancies.

It is universally acceptable for adequate health information related to the birthing process to be given during ANC visits in the form of antenatal care education which serves as a platform to inform about and discuss the birthing process. Chikalipo et al. (2018: 1) maintain that antenatal education is one of the pillars of ANC which aims at improving the health of mothers, babies, families and preparing for the overall birthing process. Furthermore, ANC education is used in dispelling first-time mothers' myths associated with the birthing process (Chikalipo, et al., 2018: 1). In a similar study Stark and Jones (2006: 4) were in support of sharing of information during ANC as some participants acknowledged that antenatal education had assisted their preparation in case of a lengthy labour and difficult birthing process occurring. While some women quoted from a different but similar study highlighted that it was through ANC health education sessions that they had developed realistic expectations (Dahlen et al., 2008: 23). Both studies therefore confirm the importance of health-related information for a birthing woman and yet in this current study that was a shortcoming. In this regard one participant had the following to say:

*"When I was at the clinic, I was never told that they **[the midwives]** will insert fingers to assess for centimetres **[digital vaginal examination]**. I only saw that when I was here **[labour ward]**. I only experienced that thing **[digital vaginal examination]** when I was here in the hospital."*

*(*P8, L94-96)

It could thus be argued that the concern by the participants about limited information shared with them in preparation for their birthing process, is valid. This event is often paired with poor birthing experiences reported by expectant women (Mukamurigo, Dencker, Ntaganira & Berg, 2017: 1). Although information sharing could be done in many ways it remains the responsibility of the midwife during ANC and labour. De Vivo and Mills (2019: 1) concur with the above-mentioned statement that midwives are crucial in the dissemination of information before and during the birthing process.

The ICM (2014: 1) advocates a midwife/woman partnership to enhance sound decision making and active sharing of information by labouring women on issues concerning their health. According to Noncungu and Chipps (2020: 9), midwives are supposed to cover pregnancy-related lifestyle and health education needs and even psycho-social health education needs. Nalan (2009: 26) recommends transmitting information to clients using resources that are less expensive than resorting to a health practitioner's time, including DVD's, CD ROMs, evidence-based leaflets and posters (Nalan, 2009: 26). Since midwives are expected to disseminate birthing process related information to birthing women, they can use available resources relevant to their context such as group sessions and printed pamphlets with the aim of enhancing birthing process preparedness.

Participants expressed the fact that limited information shared with them regarding their birthing process had contributed to their incomplete birthing process knowledge and experience. The following responses illustrate how they expressed their feelings about incomplete information about the birthing process:

*"Then with regard to birthing process they **[the midwives]** were not more specific about it. Because I didn't know like when there was that jelly **[mucus show]** that was coming out, I didn't know what did it mean, you see?"*

(P12, L20-23)

*"It was never explained under what circumstances a person is stitched, under what circumstances a person is cut **[an episiotomy]** You see? I only felt it on me when I was giving birth, that if you sustain tear you need to be stitched **[sutured]**, you will not heal on your own. And if the baby **[fetus]**, the head is not delivered, you will have to be cut **[an episiotomy]** eventually"*

(P8, L111-117)

The above responses attest that retrospectively the participants felt that the birthing process had not been comprehensively explained to them during ANC clinic visits, leaving them unaware of some of the birthing process inevitabilities such as procedures necessary during the birthing process and therefore unhappy. One inevitability mentioned by participants was the sign of imminent birth, the presence of a show which is a crucial sign for mental preparation in labour.

Besides mental preparedness the woman should seek advice from the midwife and prepare for admittance to the labour unit soon after the show of mucus, a positive indication of the onset of show. This is one of positive signs of labour and requires monitoring thereof. In a study done in Malawi about antenatal education content, signs of labour were thought to enhance timely birthing by a skilled attendant such as a midwife as the women would know that, upon experiencing of those signs, she should go to hospital (Chikalipo, et al., 2018: 10).

Furthermore, in this study one of participants highlighted the fact that she had not received information about the possible duration of birthing pains and that also, there would be recurrent vaginal examinations to assess her progress of labour, hence her surprise when it happened. This confirms previous comments about how poorly informed these participants were about what would be done by midwives during their birthing process. To this effect one participant said:

*"… so that was something I didn't expect that they **[the pains]** will take long hours and that I would be checked how many centimetres **[digital vaginal examination]** I am and all that blah! blah! I was not told about those things **[at the clinic]**; I was only told about the pains. That what will happen regarding other things and how long I should wait … I thought I will feel the pain and give birth, that's all."*

(P14, L56-60)

Based on the above response, it seems that the participants had proceeded to the birthing process without enough knowledge of possible occurrences or necessary procedures involved. In a similar study done in Nepal, Silwal, Poudyal, Shah, Parajuli, Basaula, Munikar and Thapa (2020: 1) reported that adequate knowledge of the birthing process was a precursor for better preparedness among birthing women which made the researcher question the preparedness of the participants of this study. On the contrary, in a study done about knowledge and attitudes towards birth preparedness among primigravid mothers in Uganda, the majority (56%) of women had been found to have sound knowledge of birthing preparedness (Okello & Akatuhurira, 2019:17). In a study done by Maputle and Hiss (2010: 9) in Limpopo about midwives' experiences of managing women in labour, midwives had found that women who lacked information regarding the birthing process were disregarding instructions,

uncooperative and at times refusing necessary birthing process procedures such as vaginal examinations.

Despite the lack of preparation for necessary birthing procedures such as digital vaginal examinations of participants in this study, they did not dispute the necessary birthing process procedures. They voiced their dissatisfaction at having to discover about those procedures only when these were performed on them. In this regard one participant said:

*"Yeah! I was not happy, but here is my bundle of joy* ***[referring to the infant]*** ***[laughing]*** *… But next time I hope they* ***[the midwives]*** *will explain to us and others* ***[pregnant women]*** *the things that we should expect* ***[during the birthing process].*** *And I also witnessed on my own how is it happening even if they* ***[the midwives]*** *do not explain for me, I have witnessed it on my own, how it is happening."*

(P5, L309-314)

To eliminate such negative experiences as the one mentioned above, for example, in Sweden antenatal classes are said to be precisely for first-time mothers (Barimani et al., 2018: 1). Approximately 67% of the antenatal health education and preparation in Sweden is devoted merely to birthing process preparedness such as length and stages, possibility of complications and tearing and cutting of episiotomy (Barimani, et al., 2018: 4). In the context of this study the midwives and their managers could learn from this strategy and benefit the first-time mothers.

Interestingly and in contrast to the many negative experiences shared above, one participant reported a positive experience as she had received some satisfactory information regarding some of the procedures to anticipate during the birthing process. The following response illustrates how the participant expressed herself having been informed of associated birthing process procedures:

*"What I heard here is that the machine* ***[CTG]*** *is … that machine with the belt, is to assess how the baby's* ***[fetus]*** *heart is, and assesses the pain. Yes, it is like that"*

(P8, L86-87)

This statement should, however, be viewed under the philosophy of individualisation and uniqueness because people may differ in their view of the same matter depending

on their attitudes or knowledge of detail. The above response indicates that some midwives do indeed provide valid scientific information about birthing process procedures to pregnant women.

According to Kabo, Holroyd, Edwards and Sarki (2019: 3), in a study done in Kenya about socio-demographic factors associated with mothers' experiences of psychosocial care and communication provided by midwives during childbirth, the majority (91.7%) of participants indicated that midwives had explained the birthing process and its associated procedures to them resulting in those participants regarding the birthing process as a positive experience (Kabo et al., 2019: 3). The findings of the above study are consistent with those of this study. The assumption is that participants would be more cooperative if they were well informed about the necessity of those birthing process procedures which corroborates what Maputle and Hiss (2010: 9) reported, namely, that women who had received accurate and complete information regarding the birthing process were empowered and able to make informed choices and cope with all aspects of the birthing process.

It is therefore the role of a midwife to ensure that the birthing women have understood the information provided and discussed in order to ensure participative and cooperative behaviour during the birthing process and give meaning to it all. In this regard one participant voiced the inability to understand the information shared by the midwives as follows:

*"I didn't understand that thing, because they **[the midwives]** wouldn't explain what does that thirty something mean **[referring to gestational age]**. But when it comes to that I searched on google, it **[google]** would explain what does it mean that thirty-four weeks. What would happen"*

(P6, L195-199)

Regarding communication and understanding during the birthing process, Ahmed (2020:3) found that midwives did not allow adequate time for birthing women to ask questions about subjects or issues they did not understand concerning their birthing process. The above-mentioned tendency might act against the goals of ANC visits to empower the woman for the purpose of a positive labour outcome.

*5.2.2.2 Sub-theme 2.2: Ineffectiveness of pain relief strategies.*

According to Dippenaar and da Serra (2018: 410), women anticipating the birth of a child are often concerned whether they would be able to cope with inevitable birthing process pains which women should expect during the birthing process. There are various sources of pain that can be experienced during the birthing process, for example, those imposed by birthing procedures such as digital vaginal examinations and cutting of the episiotomy. However, the primary source of pain during birthing is that of uterine contractions (Dippenaar & da Serra, 2018: 412). Contractions are a physiological response of the uterus in preparation for the birthing of the baby. According to Dippenaar and da Serra (2018: 372), contractions which are regular, rhythmic and often painful subsequently lead to the expulsion of the baby.

Birthing process pains are initiated by the combination of hormonal and mechanical factors, which cause painful contractions coupled with cervical dilatation and ultimately, the birthing of the baby (Dippenaar & de Serra, 2018: 372). Physiologically contractions are necessary for birth of the baby to take place; so, since the birthing process pains are inevitable and necessary, the first-time mothers should be educated about them and taught how to respond to them. Some participants reported having been informed about these contractions during their birthing process preparation and their expected way to respond to those pains. The participants had the following to say:

*"Because, even here when I was in labour **[having contractions]** they **[the midwives]** told me to breathe in and out **[breathing exercise]** and then I remember that at the clinic as well I was told that"*

(P11, L-229-230)

*You are told there **[at the clinic]** that there is no medicine for the pains **[contractions]** to begin with and then if, there may be the baby is still far. You will have to take a walk or you sit on that ball **[birthing ball]**, keep on sitting on it, the baby **[fetus]** will eventual come **[delivered]**.*

(P9, L111-114)

*"It was mostly the breathing part **[breathing exercise]** because, yho! It **[contraction]** was coming and going I had to **[breathe in and out]** I remember, okay I read there by*

*Mom-connect that you have to breath in, not too hard not to …not too hard to breath, not too slow every time when there comes the pain then you breath, like that."*

(P15, L126-130)

The responses provided demonstrate that the participants were informed about the birthing process pains during their birthing process preparation and how to manage those pain using non-pharmacological strategies. Although not mentioned to the participants, non-pharmacological strategies are acknowledged for their minimal or absence of harm to the expectant mother, unborn baby, the progress of birthing, user-friendliness and cost-effectiveness (Boateng, Kum & Diji, 2019: 2). Furthermore, these non-pharmacological strategies are acknowledged to facilitate vaginal birth and shorten the duration of labour (Yuksel, Cayir, Kosan & Tastan, 2017:1; James & Hudeck, 2017: 40). It is evident that there had been discussion between midwives and the participants about the use of non-pharmacological strategies as a response to birthing pains, such as breathing exercises, walking and use of a birthing ball. Consequently, participants in this study had been informed about these strategies. Differently, in a study conducted in the Eastern Cape to explore knowledge of birthing process pain relief during the birthing process, only 29% of the participants had knowledge of breathing exercises which is a non-pharmacological strategy (Mugambe, Nel, Hiemstra & Steinberg, 2007: 16). Some of the participants in this study, though not many, reported knowing about pain management strategies.

Unrelieved birthing pains can result in negative consequences such as stress, fear and depression in birthing women, the attending midwife and family (Boateng et al., 2019:1). Negative consequences are more prominent in labouring women and have implications for the unborn baby since they may compromise placental perfusion and cause possible fetal complications such as hypoxia (Macdonald & Magill-Cuerden, 2012: 865). On the other hand, while acknowledging that some women view labouring pain as a positive sign of birthing progress and may refuse analgesics (Mugambe, et al., 2007:16), to avoid the consequences of birthing process pain and anxiety (Yuksen et al.,2017: 2), all women should receive reasonable relief from painful uterine contractions. Effective pain relief strategies are an important component of the care plan for the birthing woman (Thompson, Feeley, Moran & Oladapo, 2019: 2) otherwise

ineffective management of contractions may be associated with poor satisfaction of women's childbirth experience (Ohaeri, Owolabi & Ingwu, 2019: 2).

When non-pharmacological pain management strategies are failing, stronger medication is recommended with merit. According to Dippenaar and de Serra (2018: 421), should uterine contractions fail to respond to non-pharmacological strategies, pharmacological agents may be necessary to control contractions. Such a step was limited in this study; but literature states that some women cope well with birthing pains without any pain relief agent while others require non-pharmacological or pharmacological strategies for pain relief (Thompson et al., 2019: 2). Midwives are therefore expected to respond appropriately to women's requests for pain relief during the birthing process. Participants expressed their experience of ineffective pain relief strategies used during their birthing process, one of which was shared as follows:

*"Ever since I had been dragging and doing the same thing, I had been doing the breathing in and breathing out* ***[breathing exercise]****, it did not help me anyway."*

(P10, L-231-234)

Non-pharmacological strategies are said to alleviate pain through inducing a birthing woman to be calm and distracted (Thompson et al., 2019: 2). In other studies, done by Aziato, Acheampong and Umoar (2017: 5); Yuksel et al. (2017: 1), it was found that breathing exercises during painful contractions helped women alleviate their contractions themselves. With reference to the specific participant in this study, since the strategy was not effective, the unrelieved birthing pains could have resulted in fetal distress (Dippenaar & da Serra, 2018: 421) indicating that failure of non-pharmacological strategies warrants the use of pharmacological strategies to relieve painful contractions.

There are diverse reasons for the use of pharmacological methods, particularly pethidine which is the most frequently used analgesic in South Africa (Fraser, Cooper & Nolte, 2010: 495). Th pethidine injection is an acceptable pain relief medication given four-hourly in both latent and active phases of the birthing process (DoH, 2016: 42). In this study participants further denied the effectiveness of pharmacological strategies such as Pethidine and Panado which had been administered to relieve

pains during their birthing process and the following responses demonstrate how participants regarded ineffectiveness of pharmacological strategies:

*"Even if you are given **[pain relief medication]** … cause they **[the midwives]** had injected me pain relief medication **[pethidine]** but it didn't help. The only thing it did, was to make me drowsy only, you, see?"*

(P14, L314-316)

"*Yhoo! Like those pains became serious **[severe]**, when I came here **[in the hospital]** then they injected me **[pethidine]** to reduce pains and that I sleep but nothing happened, instead the pains increased."*

(P4, L238-240)

"*I was not used to these kinds of pains, which were unlike the first ones. I drank panado **[to relieve birthing pains]** assuming that I will be alright, there was just no effect."*

(P5, L128-130)

Some participants as indicated above were given an injection which the researcher assumes to be pethidine; but it did not work. Even though Pethidine is acknowledged for its effectiveness in providing some pain relief it is also associated occasionally with nausea and vomiting if the patient is allergic to it (Macdonald & Magill-Cuerden, 2012: 528). This had happened with the participants mentioned above. Since it is not generally known to exacerbate pain, this experience of the participant may not be dismissed as impossible and may need further investigation. Results in the study of Thomson et al. (2019: 13) revealed that some participants had found pethidine to be effective in relieving their birthing process pains, affording them an opportunity to feel in control over the contractions while others reported the opposite. Aziato et al. (2017: 5) found in their study about labour pain experiences and perceptions that some women concurred about having experienced relief when they were given analgesics such as pethidine; so, there is a grey line regarding the effectiveness of pharmacological strategies during labour as the available literature is in conflict about the experiences expressed in this study. Participants have recommended some closer assessment of the effects of any pain control measures given to women during labour.

*5.2.2.3 Sub-theme 2.3: Birthing process preparation received from varied sources.*

While provision of skilled midwives and effective obstetric services is advocated for the birthing process preparation, Abbyad and Robertson (2011: 46) acknowledge the validity of other informal sources to assist in birthing process preparation. Martin et al. (2013: 103) concur with the above-mentioned authors that birthing process preparation can also be obtained from varied sources such as childbirth classes, books, television, the Internet, healthcare providers, magazines or family and friends' hearsay. Sengane (2013: 1) agrees with other authors that all the above sources play a significant role in birthing process preparedness of an expectant woman. Ranie (2019: 2) regards formal and informal birthing process preparation from partners, relatives and midwives as a norm and helpful to expectant women as it reduces fear of labour pain. Duncan et al. (2017: 2), however, caution that the effectiveness of informal education coming from friends often leads to women doubting their birthing process coping abilities, the reason being those stories concerning the pain of contractions are often exaggerated and hinder the acceptance of valid preparation and related information, consequently misleading labouring women. The content of varied sources requires to be evaluated as it may be inaccurate or unscientific. Women who rely on unscientific sources are therefore vulnerable since they are at the receiving end of poor birthing process preparation from these sources. The findings of the study done by Javanmardi et al. (2019: 5) about Internet usage among pregnant women seeking health information, portrayed failure of expectant women to make a distinction between correct and incorrect birthing-related information. Findings from their study therefore maintained that pregnant women were at times exposed to conflicting information about birthing process preparation from varied sources resulting in poor decisions about birthing process preparation.

In this study participants mentioned having received birthing process preparation from varied sources in addition to the midwives, such as family members, friends, Mom-connect and internet and expressed their thoughts regarding these sources as follows:

*"...as I said that, for me I had to hear it **[birthing process]** from someone who had experienced **[the birthing process]** to understand what is going to happen."*

(P15, L118-119)

"*I was googling **[using internet]** whatever I was not sure about **[regarding birthing process]***."

(P3, L292)

*"They **[the midwives]** had a very big role because every time I had to go to the clinic, they **[the midwives]** told me something new. Like the baby is growing, there is a heartbeat, there's medication **[that]** helps baby to move and staff like that. I think it had a big role in my pregnancy because I didn't know most of the staff that they **[the midwives]** taught me there **[at the clinic]** around the baby."*

(P15, L192-197)

The findings of a meta-synthesis done by Lunda, Minnie and Benade (2018: 4) about women's experiences of continuous support during childbirth support the findings of this study. It found that midwives, doulas, husbands, female relatives or friends had played a significant role in birthing process preparedness of the participants in that study (Lunda et al., 2018: 4). Furthermore, Spencer, du Preez and Minnie (2018: 1) attest that the birthing woman may pursue birthing process preparation from sources such as friends or family members, other than midwife and doula. In the above responses one participant reported having consulted another woman who had experienced the birthing process in order for her to be able conceptualise the birthing process. It was therefore evidence for this study that women with experience of the birthing process are resourceful in coaching first-time birthing women. In support of the above statement one participant said:

*"People **[women]** who had given birth before, **[they]** were looking at us **[at labour ward]** as we were doing things … we were guided by them **[instructing us to]** breathe, do that and that, we **[as first-time mothers]** didn't even know what we should do."* (P7, L244-248)

In the response above the participant in this study acknowledged the assistance from the women who had experienced the birthing process for instructing her on ways to respond during labour, indicating the value of the assistance from women with experience of the birthing process. Dahlen et al. (2008: 22) concur that it is common practice for birthing process experience to be passed on from experienced mothers. Klomp et al. (2017: 96), however, caution that one needs to acknowledge that such

birthing process experience is not always factual and can instead result in women being unsecure and rather fearful of the birthing process because of the potential of exaggerating the implications or duration of the birthing process. According to Javanmardi et al. (2019: 5), incorrect information such as that from a friend can cause anxiety in expectant women. The findings of the study done by Ibach et al. (2007: 462) about knowledge and expectations of labour among primigravid women found that participants had consulted other women attending the antenatal clinic to assimilate knowledge about the birthing process. The findings of the above study coincide with the findings of this study in which the participants, first-time mothers, appear to have been assisted by women who had experienced the birthing process

One other participant in this study said she had used the Internet to reference and enhance her birthing process preparedness where she had observed a knowledge gap regarding the birthing process. The participant said the following:

"*I think they **[the midwives]** had told me enough and then I also made use of google search **[internet]** the moment I found out that I was pregnant, so I checked how will **it [the pregnancy]** be in certain months **[gestational age]** and how the baby would be, yeah all that." (P14, L24-27).*

One systematic review study done by Sayakhot and Carolan-Olah (2016: 7) about Internet use by pregnant women seeking pregnancy-related information found that the main reason for this action was wanting to enhance knowledge about pregnancy-related topics; so, the findings of the above study are consistent with those of with those of this study, namely, that women consult the Internet in case of information need. Javanmardi et al. (2019: 5), however, warn about the possibility of inaccurate information on various websites and social networks therefore advising women to be redirected to reliable sources since faulty internet sources can be misleading and lead to misconceptions. Although birthing women may have several information sources to choose from when seeking information, the midwife is expected to remain the most reliable and core source of information (ICM ,2014: 1).

In this study, according to some participants, the midwives had maintained the role of alleviating pain and anxiety and they further acknowledged midwives for imparting

additional knowledge. Lunda et al. (2018: 4) found that the role of midwives was perceived by women to be the medical aspect of care, consistent with the findings of this study. One participant narrated the role of midwife as follows:

*"They **[the midwives]** were attending the heartbeat, the growth, my health, my blood **[referring to blood pressure]**, is my blood not too high, is it too low, my sugar levels and am I taking my medication on regular basis and if I'm not working too hard and staff like that."* (P15, L88-91)

In the response presented above, the participant exemplified the expectant women's perception of midwives' role as professional care as the midwives had been predominantly observed to be attending to maternal and fetal wellbeing. Thorstensson, Ekstrom, Lundgren and Wahn (2012: 4) concur with this finding as results from their study revealed that midwives were more concerned about midwifery-related care such as informing about the next vaginal examination. The findings of the above study coincide with those of this study as the midwifery care appears to be a concern and a priority of midwives attending to women during the birthing process.

In addition, some participants in this study expressed having received assistance with the birthing preparation from their families, viewing this kind of birthing preparation as support. As stated by Wehmeier et al. (2006: 1486), the concept 'support' means to give assistance, encouragement or approval. In view of the above definition, family seems to have played a significant role pertaining to psychological birthing process preparation. The participants expressed family support as follows.

*"In fact, throughout my pregnancy, my family had been one of my supportive from the go. They had been encouraging me."*

(P3, L324-326)

*"Yhoo! hayi! they **[the family]** had supported me, they gave me the suggestions that we were getting at the clinic as well."*

(P10, L92-93)

Bohren et al. (2017: 8) concur that supporting a person during the birthing process is by providing psychological, physical, emotional and practical assistance and information, which had been done by a family member according to comments from

the participants in this study. Support has been associated with reduced need for medical interventions, caesarean-section births and postpartum depression (Lunda, et al., 2018: 1). The birthing support as indicated by Marshall et al. (2016) provides a feeling of security and fulfilment to the birthing woman, consequently enhancing positive birthing outcomes.

Some participants in this study had used social media such as Facebook, YouTube and Mom-connect services as useful support services and sources which had contributed positively to their birthing process preparation. The following responses illustrate the role of media in birthing preparation as expressed by the participants:

"*They were comforting me, worse facebook because there were discussions of things like "umchamo wehashe" the things we are drinking, they were objected there*.

(P6, L164-165)

"*I would also watch when she **[the pregnant woman]** is in labour, I watch on YouTube*."

(P10, L117)

*"I'm very happy with Mom-connect, I feel it's a big help because even though after the baby **[is born]** I can still maybe go back and read **[the birthing process preparation messages]** again."*

(P15, L162-163)

Results from a scoping review conducted by Luce, Cash, Hundley, Chayne, van Teijlingen and Angeli (2016: 7) revealed that particularly first-time mothers turned to applications such as *F*acebook and WhatsApp for pregnancy and childbirth information. Furthermore, in the study done by Dekker, King and Lester (2016: 111), the majority (80.7%) of women who had participated in their study stated that they could recall maternity care information that was shared online. Also, Luce et al. (2016: 5) found that many pregnant women used media to understand what could happen during childbirth. It is therefore advisable not to undermine the value of online sources regarding birthing preparation, but instead that the content should be verified as being evidenced-based. Participants therefore provided suggestions for the midwives to

facilitate their birthing process preparedness. The next theme will elaborate on those suggestions.

### *5.3.3 Theme 3: Participants provided suggestions for midwives to facilitate their birthing process preparedness.*

The participants in this study have largely been noted to have been ill-prepared for their first-time birthing process experience, though at times attempts had been made to assist them in their birthing process preparedness. Participants cited various factors which seem to have contributed to the ill-preparedness of their birthing process. In response to those factors, participants voiced their concerns as well as some suggestions to aid in facilitating future birthing process preparedness such as special classes and counselling sessions during ANC visits. Regarding the birthing process preparation classes, one participant said:

*"For maybe two, three hours for when it's your date **[ANC return date]** maybe you come there then the nurse **[midwife]** explain to you. You see you will go now into labour; this is **[what]** going to happen, do this and do that, it's going to be helpful."* (P15, L213-216).

There is a lack of literature regarding the existence of both birthing process classes and counselling sessions in the South African public sector context; so, this suggestion is viewed as useful. In addition to those birthing process preparation classes and counselling sessions, participants suggested the need for more detailed information to be shared by midwives regarding their birthing process. In this regard one of the participants said:

*"They **[the midwives]** should be more specific, that when you will give birth, you will experience something like this and this."* (P12, L250-251).

In this response the participant sought for midwives to be more precise when preparing them for their birthing process; for, as first-time mothers they require midwives to define clearly the event of birthing process in order to enable them to conceptualise the anticipated process. Congruent with this request, results from a study of Sengane (2013: 7) about mothers' expectations of midwives' care during labour, revealed an expectation of explicit communication explaining midwives' actions and findings.

Moreover, in their study Mutabazi and Brysiewics (2021: 1) recommended that birthing women should be equipped with comprehensive knowledge about the entire birthing process. If there were to be more explicit communication by the midwife, the assumption is that expectant women would be more cooperative during the birthing process since the birthing process would have been clearly defined to them. As one participant said:

"*But if it **[birthing process]** was something that I was informed about, prior, I think I would have cooperated to the nurses **[midwives].** But I couldn't cooperate because other things I wasn't informed about."* (P6, L346-348)

From the above response it appears that for the participants in this study, the overall birthing process had not been completely explored; thus, it can be viewed as suboptimal birthing preparation. For example, the nature of the birthing process, uterine contractions and pain relief medication should have been fully discussed. Suboptimal birthing preparation had thus made some participants uncooperative during their birthing process. In a similar study done by Munkhondya et al. (2020: 308) results which were similar to the aforementioned revealed that participants had experienced a certain degree of ill-preparation for their birthing process, indicating that the findings of this study are congruent with the findings of some of the existing literature.

It appears that the mode of birthing process preparation manner in use in South African public institutions is exposing some grey areas regarding other important birthing process aspects which required to be addressed, hence the proposal for this study. Some participants said:

*"Those things **[birthing process preparation received from the clinic]** aren't satisfying because they are half **[incomplete].** Things aren't comprehensively explained **[by the midwives]**."* (P6, L187-189).

*It **[birthing process preparation]** was not right, even now there is nothing essential to grasp onto. Because they **[the midwives]** tell you different things… the other one would say less **[antenatal education]** while the other **[midwife]** would say more.*

*Yeah! … the **[midwives]** did not explain things **[birthing process]** exactly as they would unfold. But they were mentioning these things."* (P4, L112-122)

In view of these experiences, participants were asked for their suggestions in their capacity as first-time mothers regarding assistance towards improving their birthing process preparedness. Below is the discussion of the suggestions provided by the participants to enhance their birthing process preparation. These suggestions are:

- Birthing process preparation classes
- Birthing process preparation counselling sessions
- Detailed information mainly about the birthing process

A summary of theme three findings is presented in figure 5.3.

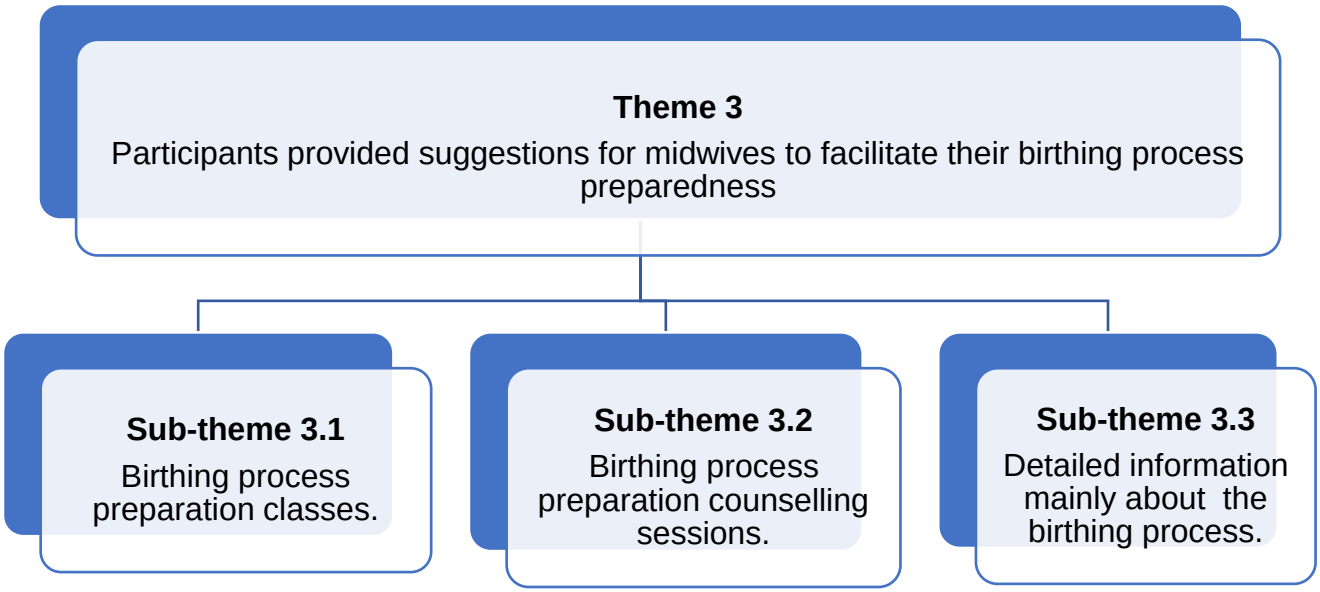



**Figure 5.3: A diagrammatical representation of theme three and related sub-themes**

*5.3.3.1 Sub-theme 3.1: Birthing process preparation classes*

Participants in this study suggested birthing process preparation classes to facilitate their birthing process preparedness. Some of the participants had the following to say regarding birthing process preparation classes:

*“Even if they **[midwives]** do just an hour of class for people **[birthing women]** who are due to give birth, to say okay now, since you are about to give birth, we want to explain that this is what is happening when you are about to give birth… people who are maybe given same time which are already nine months, categorize them, okay come at ten **[we]** will have small class before people **[other pregnant women]** are done **[their]** antenatal check-up maybe.”*

(P14, L420-433)

*“I wish it **[birthing process preparation]** could be something… **[in]** structure where it is **[provided]** in different classes. But the problem is that there **[at the antenatal clinic]** there was only one person **[midwife]**, maybe if it could be two people **[midwives]** so that the other one **[midwife]** would deal with certain class and the other **[midwife]** maybe combine certain classes. And then I think in terms of their structure it would be coherent… so that everyone coming here **[labour ward]** would be prepared as appropriate to whether the woman is giving birth for the first time or not.”*

(P3, L554-563)

***“Hlawumbe kuthiwe ngooLwezithathu kuneeklasi apho wonke umntu oqalayo ezomfundiswa ngeprocess yokubeleka. Mhlawumbi ngooLwezine, kufundiswe ngokuba ngumama, uyayibona lento? Ibizawuba bhetere, ibizawuba mnandi kakhulu iclinic.”** (Maybe say on Wednesdays, there **[could]** be classes, **[for]** everyone who is a first-timer **[expecting mother]** to be taught about birthing process. Maybe on Thursdays the teachings could be about being a mother, can you see that? It would be better; clinic would be so pleasurable).*

(P7, L347-350)

In the responses presented above the participants proposed the introduction of birthing process preparation classes, emphasising that ideally, they should be categorised for these classes according to their gestational ages. According to the participants this would enable them to receive the relevant content of the birthing process preparation depending on the stage of their pregnancy. According to Fraser et al. (2010: 199), birthing process preparation classes are resourceful in equipping expectant women with sufficient information to manage the overall birthing process.

Examples of benefits of the birthing process classes as indicated by the authors above are: addressing how maternity care functions, the physical skills for birthing, pain relief options available, signs of labour, birth plans and addressing other expectations. Furthermore, as a benefit to maternity care, Hassanzadeh et al. (2019: 6) emphasise that birthing process classes are associated with a lower rate of caesarean sections, reduced birth-related fear and anxiety and allow mothers to engage more actively in their birthing. One may categorically contend that birthing process preparation classes benefits mentioned above, were missed opportunities for some of the participants as there is uncertainty of provision made for these classes.

In many of the developed countries birthing process preparation classes are a norm, having been practised for a long time already. For example, in the USA, birthing process preparation is an organised system in the form of childbirth classes and is observed to play a significant role if it began in the third trimester of pregnancy and continued until birth (Abbyad & Robertson, 2011: 46). In addition, in the study conducted in Australia about preparation for the first-time birthing process, women acknowledged birthing process preparation classes as the most significant period to set realistic expectations (Dahlen et al., 2008: 23). In low- to-middle-income countries (LMIC's) such as South Africa, there are few comparative studies regarding birthing process preparation classes although from the data collected in this study it was indicated by some of the participants that they had attended birthing process preparation classes. In this regard participants said:

*"Usually on Fridays they **[midwives]** do not take appointments for antenatal check-ups, because they **[midwives]** are having those sessions **[birthing process preparation classes]**. Then they give people, maybe five **[pregnant women]** every week, so **[that]** they give **[other]** people chances, that is why now they cannot take people **[women]** for antenatal check-ups on Fridays."*

*(*P9, L159-162)

"***…and abasohluli, if una two months wenza laanto yenziwa ngumntu ona nine months uyabona nhe? Senza into enye sonke akohlulwa kuthiwe hayi abana nine months … abasebezobeleka mabeze apha bezothetha ngokubeleka. Abasena two months na ntoni ntoni mabeze kwelicala bazopreparwa ngenantsi, nge pregnancy. Kuthethwa nge pregnancy oko oko ukusuka ngoko una one month till uyotsho ku nine, ude uyokugqiba eclinic."*** *(…and they **[midwives]** do*

*not group us **[according to our gestational ages]**, if you have two months you do exactly the same thing as the person **[woman]** who is nine months, you see we are all doing the same thing. We are not grouped, that those who having nine months, closer to give birth come to talk about birthing process. Those with two months should come to this side so to be prepared about the pregnancy. The discussion is forever about pregnancy, from one month till nine **[months]** and then you complete at the clinic).*

(P7, L457-465)

The responses above confirm the existence of birthing process preparation classes in some of the obstetric units in the NMBHD, the area where the study was conducted. Based on the findings of this study, however, these preparation classes appear to have been presented inconsistently, making the stance of the participants regarding the classes uncertain as they shared diverse experiences in this matter and had obviously expected more comprehensive birthing process preparation classes. As one participant said:

*"I initially thought that it's **[birthing process preparation classes]** that are on-going **[norm]** at the clinic, I didn't know that there is only one thing that is being done. Every time you are given a date, you are checked only **[antenatal check-ups]**, there is nothing that you are being taught **[birthing process education]."***

(P7, L349-352)

In the response above the participant demonstrated having the insight on the differences between antenatal care and the birthing process preparation classes. The participant thus stated the concern that so-called birthing process preparation classes appear not to have been carried out and instead only routine antenatal check-ups had been done for the birthing women.

The usual antenatal booking and subsequent check-up visits include history taking, physical examination and screening tests to detect and manage existing diseases as soon as possible (DoH, 2016: 29). There is no mention of birthing process preparation classes in the information and prescriptions of antenatal care. Although Cutaja et al. (2020: 1) attest those antenatal classes are a norm world-wide as the traditional method of information sharing, such classes are still limited in the public sector

institutions in South Africa. Berimani et al. (2018:1) maintain that these antenatal classes are more prominent in developed Western countries.

The available literature maintains that unmet expectations of birthing preparation classes could cascade down to disappointments and overall negative birthing experiences (Sengane, 2013: 2; Hildingsson, 2015: 1). Negative birthing experiences should be avoided at all costs as they are thought to have an impact on the well-being and future choices of birthing women (Smarandache et al., 2016: 1), hence the participants' suggestion regarding consistent birthing process preparation classes.

*5.3.3.2 Sub-theme 3.2: Birthing process preparation counselling sessions*

In addition to the need for birthing process preparation classes, participants further suggested birthing process preparation counselling sessions. Since the birthing process is a major life transition and documented to be confusing and overwhelming (Beriman, et al., 2018: 1) the negative emotions mentioned in the comments made above by participants could be more prominent amongst the first-time mothers since they would be experiencing birth for the first time (Dixon et al., 2014: 371). Hence amongst the objectives of the birthing process preparation is to attend to those various emotions (DoH, 2016: 29) so that birthing women would be able to thrive during their first-time birthing process. To this effect, some participants in this study voiced the need for the birthing process preparation counselling sessions. The participants said:

*"For me I think they **[the midwives]** should ask you **[first-time mother],** do you feel down or do you have emotional problems…because I feel if you feel too emotional in your pregnancy it can lead to a loss of your baby, you can leave your baby **[at the hospital]**. Or you can maybe dump your baby somewhere, cause **[because]** you feel depressed, you feel there's no one caring for you. Or you think you come to the clinic for motivational words or something but they **[the midwives]** don't give it to you, that's how I feel."*

(P15, L255-275)

*"It was supposed that at least a person **[pregnant woman]** receive counselling once in a while because nine months is very long, you see … there is moss that thing where it would be said that a person **[pregnant woman]** is now in first stage **[referring to***

***first trimester]*** *and then so on …where it would be explained that okay now the baby* ***[fetus]*** *will do something like this now. Like for instance you would know that when you at six months it should be said that nhe! you can expect premature now.''*

*(P14, L385-395)*

The WHO (2016: 1) recommends adequate antenatal information and counselling for all birthing women. The information and counselling could address the health needs of the birthing woman, in terms of birth and emergency preparedness, nutrition, prevention of undesirable home practices and recognition of danger signs in order to sensitise them to care-seeking behaviour. Predominantly in this study the participants suggested that there should be birthing process preparation counselling sessions to address their psychological well-being because participants voiced how they had endured a lengthy birthing process, particularly during pregnancy which could be accompanied by moments of inevitable and unwanted emotions such as stress and depression. In view of the participants' responses above, therefore, the above-mentioned inevitable and unwanted emotions necessitate birthing process preparation counselling sessions.

According to Firouza, Kharaghani, Zenoozian, Moloodi and Jafari (2020: 2), the birthing process preparation counselling sessions should encourage women to express their feelings and help them engage with distressing components of the birthing process. For that very reason one would suggest counselling sessions to enable them to thrive during their first birthing process experience.

Amongst other things participants viewed counselling sessions as an opportunity for motivation to be given for the period of labour during the birthing process and to discuss possible pregnancy complications such as preterm birthing. Some available literature confirms the effectiveness of birthing process counselling sessions suggested by the participants in this study. To this effect, a study done by Parsa, Saeedzadeh, Masoumi and Roshanaei (2016: 202) about effectiveness of counselling in reducing anxiety among nulliparous women, yielded results pointing to a significant reduction in anxiety levels of pregnant women in the experimental group post intervention. The latter study confirmed the effectiveness of counselling sessions regarding anxiety related to the birthing process. While there is a grey area in some literature regarding the effectiveness of these birthing process preparation counselling

sessions, it is worth mentioning that some available literature reports other predicaments instead. For example, a study done by Jennings, Yebadokpo, Affo and Agbogbe (2010: 2) reported that the patients often perceived counselling to be of poor quality as a result of little useful information provided and less information-sharing than available guidelines recommended; therefore, in such circumstances one cannot confirm the effectiveness of some birthing process preparation counselling sessions.

Moreover, in another study done by Munkhondya et al. (2013: 308) about childbirth fear and preparation among primigravida, it was found that there was a gap in formal psychosocial counselling about childbirth, causing the participants of that study not to be psychologically prepared for their birthing process. The findings of that study may be in line with the findings of this study in that it appears that a lack of birthing process preparation counselling sessions was observed in both studies. Of importance to mention is that formal birthing process preparation counselling sessions are anticipated to play a role in preparing pregnant women psychologically for the birthing process (See Munkhondya et al., 2013: 308). According to Jalali, Heydarpour, Tohidinejad and Salari (2020: 1), stress as a consequence of the first-time birthing experience is acknowledged to be one of the main intense mental/social stresses. This means that, alongside pleasurable emotions associated with the birthing process, there is often the possibility of unwanted emotions such as stress, anxiety and depression. Jalala et al. (2020: 1) highlight the fact that mental disorders such as acute stress and anxiety can disrupt one's social functioning and efficiency, conditions which seem to be prevalent among birthing women (See Huizin, Menting, Moor, Verhage, Kunseler, Schuengel & Oosternman, 2017: 663).

Regarding the statement above, the researcher feels that it is worth mentioning the views of Engidaw, Mekonnen and Amogne (2019: 1) who estimated the stress prevalence to be of 5.5 to 78% among birthing women. Moreover, Abrahams, Schneider, Field and Honikman (2019:1) attest in their study that in low-to-middle-income countries (LMIC) like South Africa (SA) the prevalence of depression during pregnancy is as high as 20-26%. These figures suggest that these emotions are a shared phenomenon amongst birthing women. A participant in this study said that unrelieved stress associated with the birthing process could potentially lead to hostile thoughts such as the thought of abandoning the baby, amongst others. This means that birthing women are potentially subjected to stress during the birthing process and

cited as one of the reasons why the participants of this current study viewed psychological care as significant during birthing process preparation.

Although the various factors associated with pregnancy-related anxiety need to be acknowledged, this study did not seek to explore those factors and thus will recommend it for future investigation bearing in mind that the participants in this study had advocated counselling to reduce anxiety associated with the birthing process, especially for first-time mothers (Parsa et al., 2016: 198). To this end, the findings of a study done by Jennings et al. (2010: 12) about antenatal counselling found that antenatal health counselling was an important strategy to promote awareness during pregnancy, to maternity and later the health of the newborn. Furthermore, a study done by Berehe and Modibia (2020: 1) about quality of ANC services and their determinant factors in public health facilities of Ethiopia, found lack of proper counselling to be one of the most frequently identified problems. Since psychological status is in any case part of the important assessments post-delivery, counselling falls within this period as well but should start in the antenatal period.

*5.3.3.3 Sub-theme 3.3: Detailed information about the birthing process*

Participants in this study suggested the need for detailed information about the birthing process to facilitate their birthing process preparedness because they felt that their birthing process preparation had merely focused on the fetal well-being and neglected their birthing process preparation needs. One participant had the following to say:

*They **[the midwives]** focused on the baby **[fetus]** as such the baby is alright, but to come to labour **[birthing process],** it was never explained comprehensively. There is nothing I heard about labour **[birthing]** at the clinic, the only thing I heard was that the baby **[fetus]** is like this. We will check baby's heart… The baby **[fetus]** is growing or not growing. **[the fetus]** Is not breathing and so forth."*

(P7, L432-441)

The midwives seem to have prioritised the health of the unborn in their midwifery management and care while unconsciously compromising women's needs of birthing preparedness for their birthing process. In this regard Nilsson et al., (2013: 1) also attests that the focus of maternal and childcare has been on obstetric complications

and risks for mother and child while women's overall experience is ignored. Therefore, the results of this study are in line with the existing literature about the subject of neglected maternal well-being antenatally while midwives focus on fetal well-being.

To prevent the prevalence of the above-mentioned focus in ANC, the participants in this study suggested that there should be detailed information regarding their own need for assistance and guidance during their birthing process preparation. The participants shared the following responses:

*"**[the midwives]** should tell **[all]** the things **[that]** you will feel when you going to give birth and what happens to your body when you just close to birthing process, things like that."*

(P12, L204-208)

*"Like, it is preferable to know what is it that you are expecting. Preferable it should be the nurse **[midwife]** who is assessing you, not that you hear about it from other people. Or as I am attending here at the clinic it is preferable that you should know what is it that you going to do here **[labour ward]** when you are in labour, what is it that you are expecting. So that you will not be surprised when you get here **[labour ward]**, it shouldn't be like that."*

(P5, L283-288)

*"I think they **[midwives]** should explain the signs of labour, you see. They **[midwives]** should indicate what you should wait for, for how long, you know things like that. Also, to teach about things that are happening in labour, during the process of birthing… breaking of waters, yes and what else?"*

(P11, L240-245)

The concept "detailed" means inclusive of all possible related elements or aspects (Wehmeier et al., 2006: 398). In the light of the said definition, participants in this study suggested far-reaching birthing process preparation with discussion of all the possible related elements of the birthing process. One would assume from their comments that the participants in this study had probably received incomplete information regarding the subject of the onset of labour; so, they felt the need for detailed information in this regard. The participants highlighted the significance of knowing what to expect during

the birthing process and suggested that the detailed information about birthing process should have an emphasis on the birthing process. The following are the responses of participants regarding their preferred details about their forthcoming birthing process. Participants said:

*"They **[the midwives**] should emphasise the birthing **[process]**, **[for]** the first-timers, that as it will be your first-time expect this and this. Expect that when you are at certain centimetres **[vaginal examination]** you have so much centimetres pending. The pain starts on certain type **[level]** to certain type **[level]**. Those are the things we were supposed to be taught at the clinic before we had even arrived at the hospital for birthing."* (P7, L504-510)

***"Oh! nohlobo lento yokuba xa ulunywa ulunywa njani, uzaw feela eyiphi ipain, ziintoni ezizophuma kuwe, uzawgqabhuka amanzi kanjani xa ukwixesha elithile. Ndifeelisha ukuba nezonto mabazi discusse nabantu abaqalayo [ukuba nabantwana] … Oh! nokufaka iminwe nhe, coz xa ufika apha ufika ufakwe iminwe izinto ongazaziyo, iyakothusa ke loo nto. Mhlawumbi kubakho nokusetyenzwe ngumntu ongutata ufike ekufaka umnwe uqonde uba wothukile kengoku. Hayike umntu ongutata. Kanti if eclinic ubuchazelwe ukuba uzakufaka ne minwe ubuzoyazi ke ngoku."** (Oh! and the way of labour, how is it, what pain are you going to feel, what are the things that will come out, how are your waters going to break at certain time. I feel that those things should be discussed with first-time **[mothers]**… Oh! to be inserted the fingers as well when you get here, they **[the midwives]** insert fingers, things that you do not know about that are frightening, and maybe you are assessed by a male **[accoucheur]** and you find him inserting fingers and you will be frightened thinking, oh no the male If at the clinic were informed that there will have to insert fingers, you would know).*

(P7, L513-525).

*"If your date had arrived okay, you will give birth but now you will have labour pains, how long will you have to wait for this ten centimetres they are talking about. And that the pains will get more and more as time passes. And that there are waters that need to break during that process, before you give birth, those are the things they **[the midwives]** are not explaining."*

(P14, L413-417).

In these responses it is clear that the participants prefer detailed information on possible duration of the birthing process and contractions to enable first-time mothers in the future to be able to note when the duration of birthing process and contractions were outside an acceptable norm. The participants further voiced the need for detailed information regarding inevitable birthing procedures such as rupture of membranes and vaginal examination to ascertain progress of the birthing process. In a different context this study has yielded results similar to those of the study conducted by Felix et al. (2019: 339) about the signs of when to be alert. The above-mentioned study found that most participants of that study had not received guidance on the signs of when to be alert and about labour during birthing process preparation, concluding therefore that it is common among birthing women to receive incomplete birthing process information which in turn compromises their preparedness.

In a different study done in Amazon about experiences of antenatal and intrapartum care primiparous women attested that antenatal education was particularly significant for them to gain the knowledge required to cope with labour and the birthing process (Marsland, Meza, de Wildt & Jones, 2019: 6). Detailed information appears, therefore, to enhance women's insight into the birthing process and the expected way of responding to that process. As mentioned in the literature, antenatal classes emphasise the length of the birthing process and birthing stages, possibility of complications, tearing and cutting of episiotomy (Barimani, et al. 2018: 3). Participants were found to be adequately informed with detailed information about the birthing process enabled them to manage varying inevitable birthing process events (Barimani, et al., 2018: 40).

Since the birthing process is not always a linear process, unforeseen complications can occur which had led the participants in this study to suggest that detailed information about the birthing process should also include birthing process complications. One participant said:

*"And then tell people **[the women]** that at six months you can have premature **[labour]** and then okay."*

*(P14, L409-410)*

In the response above the participant commented that during birthing process preparation, problems that could occur during the birthing process, which is preterm labour in this regard, should be discussed. The participants acknowledged the possibility of abnormal and unpredictable complications occurring; hence they perceived the importance of being informed of those circumstances. In a study done by Slade et al. (2019: 1) seeking to establish a valid construct of fear of childbirth, birthing women expressed their fear of not knowing and not being able to plan for unpredictable complications during the birthing process. From the findings of the above study, it appears that the participants were not uncertain about the expected way of responding to birthing process complications, suggesting that birthing women should be equipped of those complications. In this regard WHO (2016: 1) suggested that all birthing women should discuss with a skilled birth attendant their written plan for birth and methods of dealing with unexpected adverse events, such as complications or emergencies.

WHO (2016: 1) further concluded that this plan would enable birthing women and their families to be adequately prepared to respond to such complications. The findings of this study are comparable with the findings of the study done by Nikiema, Beninguisse and Haggerty (2009: 327) about providing information during antenatal visits on pregnancy complications. Results in that study showed that there was a high level of unmet need for information on pregnancy and complications in Sub-Saharan Africa, particularly amongst the women who had barriers to access care if complications occurred. The findings of a different study done by Letose, Admassu and Tura (2020: 1) revealed that the overall preparedness for birth and possible complications was low though higher among urban respondents.

The results of the above-mentioned study further confirm the need for detailed information on inevitable birthing complications to enhance birthing women's preparedness. In this regard the participants suggested that there should be visuals of birthing process events to assimilate the birthing process. In this regard the participants said:

*"There should be practical, like there should be dolls at the clinic. We **[first-time expecting mothers]** should do exercises that when you will be in labour it will be like this. This will happen, you will experience something like this and this."*

(P10, L219-221)

***"…ngokubona kwam makuthethwe uba ngabana umntu xana eya kwi true labour not like false labour, makalindele ntoni na. like if ever noba kunokubakho something like iipictures kanje okanye iiparagraph ngee paragraph, like uba ku step one ulindele ntoni na, yhea! Echazayo intoyokokubana, enzele ukuba kuzokwazi nabanye, nabanye uba masilindele ntoni na."*** *(…as per my judgement there should be a discussion about things that a person* ***[woman]*** *is approaching true labour, not false labour, should expect. Like if ever there could be pictures so, or paragraphs, like explaining such as step one what you* ***[pregnant woman]*** *should expect, yeah! Explaining, so that it is clear to others [****pregnant woman]*** *as well of what we should expect).*

(P5, L264-268)

***"…noba nje ziznto nje ezi pastwayo edongeni sikwazi ukuzifundela uba kwenzeka ntoni [xa kubelekwa]."*** *(…even if* ***[there are]*** *things that are pasted on the wall, so that we* ***[pregnant women would be]*** *able to read on our own; of what is happening* ***[during birthing process]****).*

(P6, L363-365)

In the responses provided above, the participants suggested simulation of the birthing process, use of birthing process pictures and birthing process information because they felt that the use of visuals would equip them satisfactorily for the birthing process. According to Wehmeier et al. (2006: 1644), the concept "visual" refers to the picture, piece of film or display used to illustrate or accompany something. In view of the above definition, using visuals would enhance women's understanding of the birthing process as these would illustrate for first-time mothers the previously unknown birthing process.

Dai, Shen, Redding and Ouyang (2021: 1) are of the opinion that the birthing process cannot be fully understood. The above authors acknowledge that simulation-based childbirth education (SBCE) provides a birthing woman with an opportunity to experience situations before they occur in a real situation, obtain realistic information and become more immersed in understanding the process of birthing. Furthermore, SBCE is said to improve the focus and concentration of expectant women (Dai et al., 2021: 5). In their study about effective antenatal education Svensson, Barclay and

Cooke (2008: 39) found that their participants acknowledged the benefit of watching birthing process-related videos to assimilate understanding of the birthing process. In a different study of simulation-based childbirth education for Chinese primiparas, Dai et al. (2021: 5) found that integration of birthing process simulation was effective in assisting pregnant women with birthing process knowledge and reducing fear caused by lack of knowledge and experience in birthing, Therefore, available literature appearing to favour simulation of the birthing process to enhance birthing process preparation of birthing women.

In this study the participants further suggested that posters to be pasted on walls of ANC clinics to enhance their birthing process preparation. In a study about information-giving and education in pregnancy Nolan (2009: 24) found that, despite the use of high-quality evidence-based leaflets about the birthing process, women still wanted to discuss the content of these leaflets with the midwives, suggesting that effectiveness of the birthing process posters can be effective only with discussion with the midwives.

Since birthing process preparation is mainly provision of information, there may be a need to ascertain if the participants have understood the birthing process preparation content or not. In this regard one participant recommended strategy to enhance their understanding of shared detailed information during birthing process preparation. The participant said:

*"To be educated bhuti **[my brother – referring to the researcher],** about everything, like it **[birthing process]** shouldn't be just about antenatal check-up only…a person **[pregnant woman]** should be asked questions you, see?"*

(P10, L201-203)

To enhance understanding of shared detailed information during the birthing process, the participant in the response above suggested that the expectant woman should be assessed by being questioned about the content covered. Since Fraser et al. (2010: 197) emphasise that one of the measurable outcomes of effective antenatal education is a knowledgeable birthing woman in possession of evidence-based information, it may be necessary to evaluate birthing process information given. The findings of this study are consistent with those of the study done by Svensson et al. (2008: 40) about

effective antenatal education in which the participants had proposed the allowing for questions to be asked after detailed information had been given.

## 5.4 Conclusion

Birthing process preparedness is the key determinant of a positive birthing process experience for birthing women. Midwives are the key role-players in birthing process preparedness of an expectant woman. Poor birthing process preparedness potentially affects women's future birthing process decisions. This study revealed that participants were largely unprepared for their birthing process. The above-mentioned unpreparedness is proved to be the result of having received limited information shared by midwives. As such, they were unaware of all that could occur during labour and the birthing process itself.

This study further revealed that participants were fearful of the birthing process, necessary birthing process procedures, unfavourable outcomes as well as birthing process pains and the ineffectiveness of pain relief strategies. Participants acknowledged receipt of some birthing process preparation from varied sources. To mitigate poor birthing process preparedness for first-time mothers, they suggested birthing process preparation classes, birthing process preparation counselling sessions and detailed information about their birthing process. The next chapter will cover the summary, limitations, recommendations and conclusion of the study.

# CHAPTER 6

# SUMMARY, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION

## 6.1 Introduction

The previous chapters presented the discussion of the evolvement and findings of this study which culminated from a set of two objectives that were responded to, through fifteen interviews conducted with first-time mothers. The research findings were supported with existing literature about the study and topic as well as from personal and professional experiences. The current chapter seeks to focus on the following:

- summary of the study,
- limitations of the study,
- recommendations for clinical practice, research, and nursing education and
- conclusion about the study.

The discussion of the focus of the chapter follows below.

## 6.2 Summary of the study

After the researcher had noted with concern the poor birthing process preparedness of first-time mothers particularly in the public obstetric units of the NMBHD, he wondered about their readiness for the birthing process. These mothers were showing signs and expressing feelings of none to limited knowledge of what to expect during birthing and thus were not fully ready for the moment of birthing. Poor birthing process preparedness has been documented to be associated with unpleasant effects (Aksoy et al., 2014: 1) hence the concern about the possible fear of future pregnancies and increased requests for caesarean section in subsequent birthing (Slade et al., 2019: 2).

Most developed countries have well documented birthing process preparation strategies and available literature has further documented that the recipients of that birthing process preparation acknowledged its effectiveness for many reasons. For example, Duncan et al., (2017:2) believe that women who were better prepared for

their birthing process had doubled their ability to cope with contractions demonstrated being more ready for their coming birthing process.

In the context of South African public health institutions midwives rely on strategies such as guidelines for maternity care and Mom-connect to guide them regarding birthing process preparation. The guidelines for maternity care in South Africa (2016: 29) and birthing process preparation focus only on the physical and psychological aspects, not mentioning the content and how execution of such birthing process preparation should materialize. Yet, in a study done by Barimani et al. (2018: 3) in Sweden, 67% of the antenatal course was allocated to birthing process preparedness.

The effectiveness of the Mom-connect strategy remains unclear regarding birthing process preparedness. Since according to Skinner et al. (2017: 2) Mom-connect was meant to complement the available services in empowering mothers to take care of their babies; thus, again no mention of birthing process preparation was made. Furthermore, BANC plus model (Hofmeyr & Mentrop, 2015: 903) adopted by the South African Department of Health is concerned only about monitoring pregnant women more frequently. There is no mention of a specific process or criteria regarding birthing process preparation for first-time mothers. To this end, there is paucity of comparative studies regarding women's birthing process preparedness in South Africa.

The study was driven by two objectives, namely, to:

- explore and describe the birthing process preparedness of first-time mothers in the public obstetric units of the NMBHD and
- formulate recommendations for the midwives and nurse managers that would aid them in facilitating birthing preparedness of first-time mothers for the birthing process in public obstetric units in the NMBHD.

To achieve objective one, the researcher used a qualitative research design and adopted exploratory, descriptive and contextual approach. Fifteen interviews were conducted and recorded, transcribed verbatim and analysed with guidance from the thematic method of data analysis. The data collected yielded to three main themes and eight related sub-themes. The three main themes that emerged from the data are as follows.

- Theme 1: Participants shared their experiences regarding the birthing process and their birthing process preparedness.
- Theme 2: Participants expressed having had varied experiences from factors that had influenced their birthing preparedness.
- Theme 3: Participants provided suggestions for midwives to facilitate their birthing process preparedness.

The summary of these results follows below.

### *6.3.1 Theme 1: Participants shared their experiences regarding the birthing process and their birthing process preparedness.*

Most participants were fearful of their birthing process having experienced fears linked to contractions, birthing process procedures and anticipated unfavourable outcomes. It emerged from the findings of this study that participants were fearful because of lack of the birthing process knowledge, thus not knowing how the birthing process would unfold and, as some participants noted birthing process outcomes to be inevitable in nature. Therefore, they shared their experiences of being fearful of those unfavourable outcomes such as losing the baby during their birthing process.

Another source of fear in this study appeared to be the contractions. Although the participants acknowledged having expected a painful birthing process however, they confessed to have expected those pains to be lesser extreme than they had expected. In response to severe birthing process pains experienced, participants voiced having been frustrated and wished for the birthing process to be shorter. While some participants in this study did appear to have associated cumulating contractions with the progress of the birthing process, others had questioned the accumulating birthing process pains from their attending midwives.

Moreover, participants in this study stated that the necessary birthing process procedures, such as digital vaginal examination and fetal monitoring through CTG had aggravated the contractions and were resistant to accepting the necessity for birthing process procedures. The participants acknowledged fetal monitoring by CTG as one of the sources of birthing process pain but demonstrated insight into the importance

of CTG in monitoring their unborn babies and knew they should cooperate regardless of the associated pain.

It also emerged in this theme that, in retrospect, participants felt largely unprepared for their birthing process. Participants seemed to acknowledge that inadequate birthing process preparation had provided them with necessary information only pertaining to their pregnancy. As such, participants cited largely unaware of what lay ahead in the actual birthing process and did not know how to respond constructively to the birthing process when it started. For this reason, participants confessed to being shocked upon experiencing other unexpected birthing process aspects.

### *6.3.2 Theme 2: Participants expressed having had varied experiences from factors that had influenced their birthing process preparedness.*

Participants highlighted factors which were thought to influence birthing process preparedness in positive and negative manner. Limited information shared by the midwives regarding the birthing process was expressed by the participants as one of the factors that was thought to influence the birthing process in a negative manner. As a consequence, participants were unaware of some of the birthing process inevitabilities such as procedures necessary during the birthing process. For example, participants had not received sufficient information on signs of the imminent birthing process, such as presence of a show it seems that there was limited information on the duration of birthing pains and that there would be recurrent vaginal examinations to assess the woman's progress of labour but did not dispute the need for those procedures. Their dissatisfaction stemmed from having to discover about those procedures only when they were performed on them. The findings from this study revealed that, while midwives provided valid and scientific information to women regarding birthing process procedures, at times participants were unable to understand the information due to its complexity and its scientific nature.

In another instance participants expressed having been informed of inevitable contractions associated with the birthing process. The findings of this study, show that the midwives and Mom-connect suggesting to participants that they respond to birthing pains with non-pharmacological strategies such as breathing exercises, walking and

using the birthing ball to alleviate contractions. In this study, however, participants had generally denied the effectiveness of both non-pharmacological strategies and pharmacological strategies to relieve contractions because they reported having suffered from drowsiness and exacerbated pain sometimes caused by Pethidine and Panado.

Participants acknowledged having received birthing process preparation from varied sources in addition to what was given by midwives such as family members, friends, Mom-connect and the Internet. Some participants expressed having used the Internet, and social media such as Mom-Connect services, Facebook and Youtube to reference and enhance the understanding of their birthing process preparedness where there was observed to be a knowledge gap regarding the birthing process whereas they perceived midwives' role to be in professional nature as in attending only to maternal and fetal wellbeing.

### *6.2.3 Theme 3: Participants provided suggestions for midwives to facilitate their birthing process preparedness*

Objective two of this study was to formulate recommendations for the midwives and nurse managers that would aid them in facilitating the readiness of first-time mothers for the birthing process in public obstetric units in the NMBHD. Therefore, as the starting premise for these recommendations, the participants were asked to provide suggestions for midwives to facilitate their birthing process preparedness after they had explored and described the subject. Those suggestions were birthing process preparation classes, birthing process preparation counselling sessions as well as detailed information mainly about the birthing process itself.

## 6.3 Recommendations

The recommendations which were based on the findings of this study were made for midwives and managers about clinical care, nursing education and future midwifery research. The recommendations are as follows:

### *6.3.1 Recommendations for midwives and managers*

Although participants admitted to being largely unprepared for their first-time birthing process experience, they argued that it was the result of the unclear information they had received during their ANC visits and had therefore not known how to respond to the birthing process events. Therefore, looking at participants' experiences, the researcher recommended the following steps:

- establishment of uniform birthing process preparation classes compatible with those of other countries having a proven record of effective birthing process preparation classes;
- in-service training for midwives on comprehensive and uniform birthing process health education to enhance birthing mothers' knowledge of the birthing process;
- initiating training to facilitate the use of updated visual material for birthing process preparation;
- benchmarking of a tool used for birthing process preparation in developed countries; and
- in-service training for midwives on counselling needs and counselling strategies for birthing women.

### *6.3.2 Recommendations for nursing education*

Based on the findings of this study the following recommendations for nursing education were made.

- Integration of birthing process preparation education in undergraduate midwifery curriculum programmes should be implemented in SA and in countries with a similar phenomenon, enabling students to acquire relevant and uniform knowledge to be implemented in practice.
- Unpacking and integrating of content of current antenatal classes into midwifery curriculum by nurse educators would enable implementation in practice.
- Including antenatal counselling should feature in the undergraduate midwifery curriculum programmes to equip midwifery students with communication skills and relevant counselling strategies related to birthing process preparation.

### *6.3.3 Recommendations for research*

Based on the findings of this study, the researcher recommended the following research topics for the future:

- conducting a similar study on a wider scale to establish the extent of poor birthing process preparedness because of the diverse experiences most often shared by the participants;
- alternatively, a similar study in the context of quantitative design so that there could be generalisation of the findings;
- a study on the effects of pethidine on birthing women; and
- a study to investigate the effects of anxiety on the birthing process.

## 6.4 Limitations of the study

According to Theofanidis and Fountouki (2018: 156), limitations refer to potential weaknesses observed in the study that are often out of a researcher's control or restrictions which are inevitable as they are out of researcher's control. Limitations, which should therefore be clearly acknowledged in a study (Theofanidis & Fountouki, 2018: 156) were in this study associated with research design used, funding, other factors and ultimately potential impacts on findings and conclusions of the study (Theofanidis & Fountouki, 2018: 155; Ross, Nikki & Zaidi, 2019: 261). These limitations had to be acknowledged as they were potentially impacting on the findings of this study.

The limitations of the study were the following.

- The paucity of South African literature on the subject was identified, making comparisons of the findings with contexts of a similar nature a challenge at times.
- The majority of interviews took place immediately after the consent to participate on the study had been obtained, leaving participants little time to prepare and collect their birthing process experiences.
- Since the scope of this study was limited to one district and sample to fifteen participants, its findings cannot be generalised to birthing process

preparedness of the first-time mothers in South Africa and the reason why recommendations were made regarding future research in section 6.3.3.

## 6.5 Conclusion

The purpose of this study was to understand the birthing process preparedness of first-time mothers in the public obstetric units of the NMBHD. The data generated was used to formulate recommendations for the midwives and nurse managers that would aid them in facilitating the readiness of first-time mothers for the birthing process in public obstetric units of the NMBHD. The two objectives of the study were met successfully.

## 6.6 Conclusion of the study

The study aimed to gather information related to birthing process preparedness of first-time mothers of the birthing process. The participants allowed were those that were first-time mothers but were between 18 and 30 years of age. They had to be classified as low-risk women in their pregnancies and labour. The research design for the study was a qualitative one that used exploratory, descriptive and contextual approach to explore and describe birthing process preparedness of first-time mothers in the public obstetric units of the NMBHD. The data collected was used to formulate recommendations for clinical midwifery, nursing education and research. Limitations of the study were acknowledged for possibly having affected the findings of this study.

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## ANNEXURE A: LETTER TO PARTICIPANT/RESPONDENT

NELSON MANDELA UNIVERSITY

**October 2018**

Dear Madam

| ***Aspect*** | ***Explanation*** |
|---|---|
| **1. Interview location and venue** | Your interview will take place at the obstetric unit/ postnatal clinic in a convenient, closed and safe venue. Or at any place convenient for you |
| **2. Process** | The interviews will be conducted by a male researcher. By signing the accompanying consent form, you agree to participate. You will be asked about your birthing process preparedness as the first-time mother. Interviews will be recorded on an audio- tape recorder. No personal information such as name or address will be recorded. Your identity will not be revealed in any discussion or publication. Furthermore, your voice will not be identified or used against you, beyond the objectives of this study. Instead, pseudonyms will be used on all transcripts. Information provided will be stored strictly confidentially under lock and key, for analysis, verification and publication and will be accessible only to the researcher, supervisor and co-supervisor for five years, after which it will be destroyed. Interview will take a maximum of 40 minutes. |

| | |
|---|---|
| **2. Possible risks and interventions** | During the process there is a possible risk of unfavourable emotions and embarrassment being prompted. You will be counselled by an experienced counsellor arranged by the researcher and also if you require immediate management while arranging further referrals. Transportation for such services will be arranged by researcher |
| **3. Possible benefits** | You will have an opportunity to ask questions that may be of concern, the benefit of which will be for future first-time mothers who will have access to opportunities for better birthing process preparedness. |
| **5. Rights** | You have the right to voice feelings of discomfort or embarrassment at any time and to withdraw from participation in the study at any time without fear that the researcher might withdraw care due to you.<br><br>The level best maternity/medical services due to you are guaranteed regardless of your choice of not participating in and/or withdrawing from the study. Under no circumstances will you be coerced into participating or be penalised for non-participation. |

**RE: REQUEST FOR YOU TO TAKE PART IN A RESEARCH STUDY**

I, Xolani Dlamini, am a Masters student at the Nelson Mandela University in Port Elizabeth. I plan to do research on a topic with the title: *Birthing process preparedness of first-time mothers in the public obstetric units of the Nelson Mandela Bay Health District.*

The supervisor of this research is Professor S James (Nelson Mandela University, Port Elizabeth). The research aims are to:

- explore and describe the experiences of first-time mothers on their preparedness for their birthing process and
- based on the findings, formulate recommendations for antenatal care clinics and labour ward midwives to aid them in enhancing the standard of preparation for the birthing process for first-time mothers.

I hereby request your permission to participate in my study. For further information, please do not hesitate to contact my supervisor, Professor S James (Nelson Mandela University, Port Elizabeth) at Sindiwe.James@mandela.ac.za or the researcher on 0788760994
or s210022515@mandela.ac.za or Research ethics committee: Human (REC-H), Professor C Cilliers (Nelson Mandela University, Port Elizabeth) at charmain.cilliers@mandela.ac.za.

Yours sincerely,

**ANNEXURE B: CONSENT FORM**

NELSON MANDELA
UNIVERSITY

**CONSENT FORM**

**Title:** *Birthing process preparedness of first-time mothers in the public obstetric units of the Nelson Mandela Bay Health District*.

I give consent for you to interview me and I am willing to participate in the above-mentioned project. I have read the accompanying letter explaining the purpose of the research project and understand the following conditions:

- My participation is voluntary.
- I am aware that the researcher is a male midwife and I do not object to being interviewed by him.
- I may decide to withdraw at any time without penalty and already collected information will then be destroyed and not used in the study
- The whole interview session will be recorded and stored for later analysis and confirmation.
- I am entitled to the best maternity/medical services due to me regardless of my choice of not participating and/or withdrawing from the study.
- All information obtained will be treated in strictest confidence
- My name will not be identifiable and used in any written reports

I may seek further information on the project from Mr Xolani Dlamini on Mobile: 0788760994 or e-mail address: s210022515@mandela.c.za.

_____ _____

Name Signature

_____

Date

## ANNEXURE C: LETTER TO THE DEPARTMENT OF HEALTH

NELSON MANDELA UNIVERSITY

**October 2018**

Office of the Clinical Governance Manager
Department of Health: Eastern Cape
Nelson Mandela Bay Health district
Private bag x28000
Greenacres
Port Elizabeth
6057
REPUBLIC OF SOUTH AFRICA

Dear Sir/Madam

**RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT A PUBLIC HOSPITAL IN THE NELSON MANDELA BAY HEALTH DISTRICT.**

I, Mr Xolani Dlamini, am a *Master's* student at the Nelson Mandela University in Port Elizabeth. I plan to do research on a topic with the title: *Birthing process preparedness of first-time mothers in the public obstetric units of the Nelson Mandela Bay Health District*.

This project will be conducted under the supervision of Professor S James (Nelson Mandela University, Port Elizabeth). The objectives of the study will be to:

- explore and describe the experiences of first-time mothers on their preparedness for the birthing process and,
- based on the findings, formulate recommendations for antenatal care clinics and labour ward midwives to aid them in improving the standards of preparation for the birthing process for first-time mothers.

The researcher will conduct interviews with patients. The role of NMBHD is voluntary and may decide to withdraw the district's participation at any time without penalty.

Only patients who have signed the consent form will participate in the project. Furthermore, all information obtained will be treated in strictest confidence. The participants' names will not be identifiable and used in any written reports.

I have provided you with a copy of my proposal which includes a copy of a consent form to be used in the research process, as well as a copy of the approval letter from the Nelson Mandela University Research Ethics Committee (Human). I am hereby seeking your consent to conduct research at NMBHD hospitals and to be able to approach operational managers and patients to participate in my study.

For further information, please do not hesitate to contact my supervisor, Professor S James (Nelson Mandela University, Port Elizabeth) at Sindiwe.James@mandela.ac.za or the researcher Mr Xolani Dlamini on 0788760994 (mobile) or s210022515@mandela.ac.za or Research ethics committee: Human (REC-H), Professor C Cilliers (Nelson Mandela University, Port Elizabeth) at charmain.cilliers@mandela.ac.za.

Yours sincerely,

**ANNEXURE D: LETTER TO THE OBSTETRIC UNITS IN THE NMBHD**

NELSON MANDELA
UNIVERSITY

**December 2018**

The unit manager
Department of Health: Eastern Cape
Nelson Mandela Bay Health District
REPUBLIC OF SOUTH AFRICA

Dear Sir/Madam

**RE: REQUEST FOR PROVISION OF A PRIVATE VENUE AT THE OBSTETRIC UNIT IN THE NELSON MANDELA BAY HEALTH DISTRICT.**

I, Mr Xolani Dlamini, am a Master's degree student at the Nelson Mandela University in Port Elizabeth. I plan to do research on a topic with the title: *Birthing process preparedness of first-time mothers in the public obstetric units of the Nelson Mandela Bay Health District*.

This project will be conducted under the supervision of Professor S. James (Nelson Mandela University, Port Elizabeth). The objectives of the study will be to:

- explore and describe the experiences of first-time mothers on their preparedness for the birthing process and,
- based on the findings, formulate recommendations for antenatal care clinics and labour ward midwives to aid them in improving the standards of preparation for the birthing process for first-time mothers.

The researcher will conduct interviews with patients. The researcher is requesting that you provide a private venue which will be used for interviews.

The interviews are anticipated to take maximum of 40 minutes each and are not foreseen to interfere with related services that are due to continue. All the services due to both mother and newborn will receive priority. Newborn will remain with her mother during interview.

For further information, please do not hesitate to contact my supervisor, Professor S James (Nelson Mandela University, Port Elizabeth) at Sindiwe.James@mandela.ac.za or the researcher Mr Xolani Dlamini on 0788760994 (mobile) or s210022515@mandela.ac.za or Research ethics committee: Human (REC-H), Professor C Cilliers (Nelson Mandela University, Port Elizabeth) at charmain.cilliers@mandela.ac.za.

Yours sincerely,

## ANNEXURE E: INTERVIEW SCHEDULE

NELSON MANDELA UNIVERSITY

On the day of the interview, a ‘Do not disturb’ sign will be displayed at the door of the room to avoid disturbance. The researcher will greet and introduce himself to the participant and give her a brief overview of the study. Following that, permission to participate will be obtained from the participant (See Annexure A) and will endorse approval of participating by signing informed consent (see annexure B).

Main question: *“Could you tell me how ready you were for your birthing process?”*

Interview questions:

- How would you describe the preparation for your birthing process?
- How do you feel about the quality of the preparation for your birthing process provided for you during antenatal visits?
- How do you feel about the manner such as structure in which the birthing process preparation was done?
- What effect did the preparation for the birthing have on your birthing process?
- What is it that you think should be emphasised in the birthing process preparation?

Thank you.

## ANNEXTURE F: APPROVAL LETTERS

NELSON MANDELA
UNIVERSITY

PO Box 77000, Nelson Mandela University, Port Elizabeth, 6031, South Africa mandela.ac.za

Chairperson: Research Ethics Committee (Human)
Tel: +27 (0)41 504 2235
charmain.cilliers@mandela.ac.za

**NHREC registration nr:**

**REC-042508-025 Ref: [H18-HEA-NUR-021] / Approval]**

9 May 2019

Mr B Sonti
Faculty: Health Sciences

Dear Mr Sonti

**BIRTHING PROCESS PREPAREDNESS OF FIRST-TIME MOTHERS IN THE PUBLIC OBSTETRIC UNITS OF THE NELSON MANDELA BAY HEALTH DISTRICT**

PRP: Mr B Sonti
PI: Mr X Dlamini

Your above-entitled application served at the Research Ethics Committee (Human) (meeting of *27 March 2019*) for approval. The study is classified as a medium risk study. The ethics clearance reference number is **H18-HEA-NUR-021** and approval is subject to the following conditions:

1. The immediate completion and return of the attached acknowledgement to Imtiaz.Khan@mandela.ac.za, the date of receipt of such returned acknowledgement determining the final date of approval for the study where after data collection may commence.
2. Approval for data collection is for 1 calendar year from date of receipt of above-mentioned acknowledgement.
3. The submission of an annual progress report by the PRP on the data collection activities of the study
   (form RECH-004 to be made available shortly on Research Ethics Committee (Human) portal) by 15 December this year for studies approved/extended in the period October of the previous year up to and including September of this year, or 15 December next year for studies approved/extended after September this year.
4. 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 approval), completion of an extension request is required (form RECH-005 to be made available shortly on Research Ethics Committee (Human) portal)

5. 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 to be made available shortly on Research Ethics Committee (Human) portal).
6. Immediate submission (and possible discontinuation of the study in the case of serious events) of the relevant report to RECH (form RECH-007 to be made available shortly on Research Ethics Committee (Human) portal) in the event of any unanticipated problems, serious incidents or adverse events observed during the course of the study.
7. Immediate submission of a Study Termination Report to RECH (form RECH-008 to be made available shortly on Research Ethics Committee (Human) portal) upon unexpected closure/termination of study.
8. Immediate submission of a Study Exception Report of RECH (form RECH-009 to be made available shortly on Research Ethics Committee (Human) portal) in the event of any study deviations, violations and/or exceptions.
9. 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 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 Imtiaz.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 study.

Yours sincerely

**Prof C Cilliers**
**Chairperson: Research Ethics Committee (Human)**

Cc: Department of Research Capacity Development

Faculty Officer: Health Sciences

*Appendix 1: Acknowledgement of conditions for ethical approval*

Province of the

# EASTERN CAPE

HEALTH

Enquiries: Zonwabele Merile Tel no: 083 378 1202

Email: zonwabele.merile@echealth.gov.za Fax no: 043 642 1409 bate: 14 May 2019

RE: BIRTHING PROCESS PREPAREDNESS OF FIRST-TIME MOTHERS IN THE PUBLIC OBSTETRIC UNITS OF THE NELSON MANDELA BAY
HEALTH DISTRICT.EC_201905_012)

## Dear Mr Xolani Dlamini

The department would like to inform you that your application for the abovementioned research topic has been approved based on the following conditions:

1. During your study, you will follow the submitted protocol with ethical approval and can only deviate from it after having a written approval from the Department of Health in writing.

2. You are advised to ensure, observe and respect the rights and culture of your research participants and maintain confidentiality of their identities and shall remove or not collect any information which can be used to link the participants.

3. The Department of Health expects you to provide a progress update on your study every 3 months (from date you received this letter) in writing.

4. At the end of your study, you will be expected to send a full written report with your findings and implementable recommendations to the Eastern Cape Health Research Committee secretariat. You may also be invited to the department to come and present your research findings with your implementable recommendations.

5. Your results on the Eastern Cape wilt not be presented anywhere unless you have shared them with the Department of Health as indicated above.

Your compliance in this regard will be highly appreciated.

SECRETARIAT: EASTERN CAPE HEALTH RESEARCH COMMITTEE

Province of the

# EASTERN CAPE

HEALTH

Office of the Nelson Mandela Bay Health District Manager
Private Bag X28000 • Greenacres • PORT ELIZABETH • 6057 , REPUBLIC OF SOUTH AFRICA

Enquiries N Bonani
Telephone . 0413730014
Facsimile 0413734628
nondumiso.bonani@echealth.gov.za

Our Reference : PE Central MOU Your Reference:
Date: 24th/ 06/ 2019
Cell no: 060 583 5690

study Title: BIRTHING PROCESS PREPAREDNESS OF FIRST TIME MOTHERS IN THE PUBLIC OBSTETRIC UNITS OF THE NELSON MANDELA BAY HEALTH DISTRICT.

Dear Mr Xolani Dlamini.

I am happy you have been granted the permission to do the study in this unit. I am willing to give you all the necessary support.

Kindly be advised that the recruitment and interviewing must adhere to the ethical principles of the department of health and be abiding to the ethical standards set out by the institution also all conditions mentioned in the district approval letter.

We look forward to assisting you in your study.

Yours in service

Nondumiso Bonani

Operational Manager.

.....

Province of the

EASTERN CAPE HEALTH

Office of the Clinical Governance Manager
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Our Reference: RES Dlamini /2019
Your Reference:
Date: 23 MAY 2019

Mr Xolani Dlamini

S2100225150mandela.ac.za

REQUEST FOR PERMISSION TO CONDUCT RESEARCH ON THE BIRTHING PROCESS PREPAREDNESS OF FIRST-TIME MOTHERS IN THE PUBLIC OBSTETRIC UNITS OF THE NELSON MANDELA BAY HEALTH

In response to your application for permission to conduct the above research, permission is hereby granted with the following proviso:

- Health service delivery should not be disrupted under any circumstances.
- Timeous appointments must be made with the relevant persons prior to commencement of interviews/visits.
- All required data should be collected by the Researcher or a designated fieldworker (whose name should be forwarded to the relevant Sub District Coordinators prior to data collection). The Sub District Coordinators Messrs. Msutu — 083 378 1942, Koll — 060 563 1225 and Reuters — 060 557 9732 should be contacted before your visit and this letter is to be presented when visiting the facilities

The Nelson Mandela Bay Health District, as the research site, will expect a copy of the final research report when the study is completed. If the duration of the research period is required to be extended, the District Office (District Manager) should be informed accordingly.

This Office would like to wish you well in your research study.

Yours faithfully

DR L P MAYEKISO
CLINICAL GOVERNANCE MANAGER – NMBHD

Province of the
EASTERN CAPE
HEALTH

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21 October 2019

Mr X Dlamini

**RE: REQUEST TO DO RESEARCH**

Dear Mr Dlamini

Your request to do research at Dora Nginza Regional Hospital is hereby approved.

The approval is granted with the following conditions attached:

1. Adherence to the conditions as set out in the ethics approval from NMU.
2. Adherence to the conditions as set out in the approval from the ECDOH research committee.

I wish you all the success with your research.

Regards,

Dr Jaline Kotze
Senior Manager: Medical Services
Dora Nginza Regional Hospital

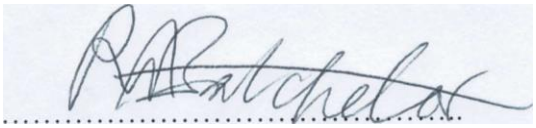
## ANNEXTURE G: LETTER FROM THE LANGUAGE EDITOR

No. 5 Villa Heights
Keith Crescent
Broadwood
2021/ 09/05

To whom it may concern

This letter is to certify that, in my capacity as a Secondary School language teacher and School Psychologist(retired), I have proofread the following dissertation for the degree of Master of Nursing of Mr Xolani Dlamini (s210022515).

The title is "Birthing Process Preparedness of first-time Mothers in the Public Obstetric Units of the Nelson Mandela Health District"



Rosemary Batchelor (Mrs)

041-3672307 / 0835909222

## ANNEXTURE H: INTERVIEW TRANSCRIPT

**R: Good evening, how are you?**

P: I am well, how are you?

**R: I am well too**

**R: I am Xolani Dlamini**

**R: I am the student at Nelson Mandela University**

**R: I am doing masters currently I am research I want to …… I am studying the experiences of first-time mothers to check if you were prepared for the birthing process, nhe!**

**R: So, since it is your first baby you happen to be my candidate, you see**

**R: E! so I will ask you those questions, I will request your responses, just relax**

**R: You see and take me through the journey**

**R: Umh! and I am not going to call you by your real name, I will refer to you as Miss O**

P: Okay

**R: So, can we start?**

P: Okay yeah (meaning yes)

**R: Okay, Miss O could you tell me how prepared were you for the birth of your child?**

P: umh! I think I was well prepared, cause at the clinic when I was there for the first time ……. I think I was four – five months then I was told what to expect, you see during the pregnancy. You know when it is you first day you do those HIV and all that before you are issued with that book (referring to MCR) and all that. And that nurse whose doing HIV test would explain about pregnancy first, way before you go inside to the nurses (midwives) who would do to you the pregnancy check-ups (antenatal check-ups). I think they (the midwives) had told me enough and then I also made

google research the moment I found out that I was pregnant. So, I checked how will it be in certain months (gestational age) and how the baby would be, yeah all that

**R: mhi!**

**R: Okay, I hear that you are saying you were well prepared but now you are telling me more or less about pregnancy, you see**

**R: So, I want now, let's go to birthing process, you see, how prepared were you for that process**

P: Okay, since I knew …… in fact I was told different dates, doctor (private doctor) had told me that I will give birth on the 27 and the clinic had told me that it will be the 22nd so I was a bit confused, you, see? Then around that time of the 20th, yeah on the 20th then I was kind of shaky, scared because I knew that my first date (referring to EDD) would arrive, you, see? And the nurse (midwife) had told me that I will give birth on the 22 and then she told me that I will have period pains, things like period pains in fact, at the beginning. I should wait first when I feel them (the pains), when I see something thick, bloodish (mucous show) I would know that I am in labour. Or my waters would break, which is I will drain waters, yeah, she (the midwife) had told me those two things and told me that if I feel those things, I should go to the hospital I am booked at. So that day I was in labour, I knew that, okay, here are the period pains are starting but I was not sure that it really them (true labour) until that thickish (mucous show) came out. Yeah, so I was well prepared for that part

**R: mhi!**

**R: Okay, so take me through when you were entering at the labour ward as you are saying you were well prepared for the birthing process, can you take me through to what was happening there and if it was what you expected**

P: Ha.a! (meaning no) it was not what I expected because I didn't know that the pains were going to be that major, cause when I got there they (the pains) were just mild, they would come and disappear but now after sometime, they got worse. So that was something I didn't expect that they (the pains) will take long hours and that I would be check how many centimetres am I and all that blah! blah! I was not told about those things; I was only told about the pains. That what will happen regarding other things and how long I should wait …. I thought I will feel the pain and give birth, that's all

**R: Okay now, what do you say? Do you say you were prepared for the birthing process if now you would reflect now that you had given birth, do you say you were prepared for the birthing process?**

P: Ha.a! (meaning no) no (laughing) I was not. Cause there was just a lot of things I was shocked about, there (labour ward). Like as I had said that I was expecting just pain and then to give birth, there is just a lot that …… and that breaking of waters. That process of breaking of waters, I just thought it will just be little water and then I would go through all that. I didn't know that I will take for hours and wait for water breaking and so forth, no I was not (prepared)

**R: So initially you indicated that you thought you were prepared for the process but later you discovered that you were not prepared, so how do you feel about that as a person who was attending the antenatal clinic?**

P: umh!I feel like they (the midwives) need to educate more, the people (the midwives) who will be the first-time mothers, you see? It should be explained deeply to them (the first-time mothers) that it will be like this and this, you will not ... they (the midwives) shouldn't just scoop on the surface. It should be explained deeply what will happen, what to expect, the pains and all that, water breakage which you need to wait for, and then after that what will happen, yeah. On other people (women) you would find that they break waters before they experience labour pains, you see. My story was different, I had labour pains for hours and then the water only broke at about ten in the evening which is I started having labour pains at one in the morning

**R: mhi! Okayl want you to tell me, for instance you were attending clinic and you thought you were prepared but when you got there you found things that you were not expecting, what is your feeling of this things just happened of thinking that you were prepared and then you found that you were not prepared when you got there, how do you feel about attending the clinic?**

P: umh! there is nothing, like I would say there is nothing wrong that they (the midwives) had done that will make me feel bad or anything, no. They had done it (the preparation) their way, I think it is their way of introducing people (pregnant women) to what is happening. And then the rest you will see it on your own after that. Moss! I was told at the hospital (labour ward) that how will I feel and then when I asked if the

pains, I had they are going to get worse or what, I was told that yes, they will get worse. The ones (labour pains) that I am having are just minor things. Yes, the clinic is assisting because everything is explained as it is said that you have these weeks (referring to gestational age) and shown how big is your baby, you see. They (the midwives) had played their part, I think, yeah.

**R: So, how do you that you were told new information at the hospital, how do you feel about that, is it supposed ……**

P: I was scared

**R: … to be like that?**

**R: Or do you feel it is supposed to be like that or what**

P: It was supposed that I knew it earlier I think, yes it was supposed that I knew it (the information) earlier in fact, yeah. Cause so that I could prepare myself, because I was scared after that after I had come back that I should wait for more pains, you see. Then I was panicking, you see. What if I was someone else just faint you see things like that, yeah

**R: Okay, I want you to tell me, you said earlier on you were given two dates**

P: mhimhi!

**R: Can you take me through that**

P: I was given two dates, 27th by the doctor, 22nd by the clinic and then in my mind I didn't want to believe the date from the clinic, I thought *mnxim!* They (the midwives) maybe are just counting. The doctor (private) since he had done the scan (ultrasound) then I thought yeah, 27th, maybe I will give birth around 25, 26 maybe. Yeah, I was confused, they (the midwives and doctor) confused me I must say. And then now I didn't expect to give birth on the 21, I was not ready at all

**R: Okay so how do you feel now about that confusion of the dates**

P: umh! there's nothing much *wethu!* It's just that I was scared you see. But everything, I was prepared for the baby everything, it is just that….. I think I was not ready; you see. So that's why I was hoping for that 27, you see, I thought yeah at least it is a bit far, yeah!

**R: So, would you say now perhaps if you had given birth or if you were going to give birth on the 27 was it going to be perhaps better?**

P: Better

**R: Or would it make you to feel better?**

P: No, I was just in denial *wethu!* That you know (laughing) I was just making myself a little bit more less scared or something, you see, yeah! So, it was just me trying to comfort myself about lies and all that (laughing). Yeah, there was nothing, I think it was going to be the same cause the was nothing going to change, I was going to experience labour pains and I was gonna (going) to give birth.

**R: Okay take me through when you were there now having labour pains, after it had been indicated to you that the pains will get worse**

P: Can you take me through that whole process that was happening there

**R: umh! as I said that I had woken up at about one because of labour pains, I went to hospital at four**

P: They (the midwives) said that I am half of a meter (meaning centimetre) ….. half of a metre. But I was not even one centimetre as per their (midwives) explanation. I did not understand that and I was like why now there is a counting of centimetres, what had happened. I didn't understand anything about that. So, they (the midwives) said I will have to go home, that too I didn't understand. How could I go home cause according to my understanding I am in labour now, but they (the midwives) had told me that I should be opened (cervical dilatation) up until ten centimetres, that was a lot for me. Because I know nothing about this (cervical dilatation). So, okay I had to go home, they kept me for four hours and then they checked me again, they (the midwives) said, no there is nothing changed, so I must go home. Truly I went home but when I got home, the pains were worse, then at about three …. They (the midwives) had assumed that I will only return in the evening. Probably in the evening I would be ready but I didn't go back in the evening, I went back at about three during the day because I was now unable to tolerate. Cause the pains for me were just too much, at three when I came back, they (the midwives) said I am three (referring to cervical dilatation). Even then I didn't understand and asked the nurse (midwife) what should it be, she said no, you need to be ten so that you are ready to give birth. And

that you still need to break the waters, then yeah! That was it until water broke around ten past ten and then I gave birth at twenty past ten

**R: Okay you are saying they were talking and saying you are half a metre how did you feel about that there were things that were done to you but you did not understand**

P: I felt clueless, because ... that is why I asked a lot of questions that what should it be, what must I do. It goes back to that the clinic did not give me enough information, even my google searching didn't give me that kind of information. I also didn't search such thing because it never crossed my mind that there are things (centimetres) that should be waited and so on. Since I knew that I will get there and have labour pains and push (the baby) only.

**R: Okay I want you to tell me about the fact you are saying you went there and then you were looked at and then you were told to go home yet you had noted or picked up that you were in labour according to your understanding**

**R: How does make person feel to go and to be told to go home because that was not it**

P: It didn't feel right to begin with because, firstly it is my first time having a baby nhe! And according to my understanding when I am in pains I should be kept at the hospital until the time arrives (birthing process). I didn't understand when I had to go and have labour pains at home because I was thinking, what if something happens to my baby whilst I am at home*, nhe!* What if that time, at about three I decided to stay and not to go back (to the clinic) thinking that I should go back at night? During that period what is it that could have happened, I was questioning myself that. What if something happens, yet I am told to be here at home, I was asking myself that question. What if I didn't have transport because to begin with, it was said that a person (woman) should have her own transport to the hospital. What if I didn't have transport, what if I relied on the public transport, what would happen? Having to take public transport home and I am in labour when I got home, what if I was staying alone, you see. It doesn't feel good. I wish a person (woman) can just stay there (at the hospital) because she is having pains and they (the midwives) could see that she is also having pains is just that she is not at this moment having these centimetres that she is supposed to have.

From sitting there, it is not even like it is full, it is empty, people should be kept there up until the right time come (birthing process).

**R: Okay, tell me about google, you said you googled and expected to be in labour and give birth**

P: Yeah! umh! on google I was not searching about labour and all that, I was searching that on a particular week, maybe I have 30 weeks now, that how is the baby, how should it (the fetus) be facing. For instance, I think I was seven months when I went for scan (ultrasound) and the baby was breech, *nhe!* And then now I didn't know in which month will it (the fetus) rotate and head face the bottom. So I checked on google that, ok it will rotate but there are possibilities that it can remain as that breech, *nhe*! Then you will be done operation (caesarean section) when you are like that, so I searched things like that, okay it will turn on what instances, on this week and how it (the fetus) is and all those

**R: Okay tell me now, about the role of google in terms of preparing for birthing process**

P: Google played a big role *wethu!* It was my every day thing, even if a feel something, I would check on google of that or I would check okay 36 weeks what to expect, yeah it kind of played a big role. Even in cases where I couldn't understand what they are talking about here, like sizes of the abdomen, that if you having twins this is the size of the abdomen, yeah!

**R: mhi! Okay umh! what are the other things …… were there perhaps other things that helped you, you had mentioned google that assisted you that you were kind of prepared**

P: umh! yeah my aunt also helped me because I was asking a lot from her about the breeching of the baby. Cause I told her (aunt) that I think the baby is breech since I saw on a scan (ultrasound) that it (the fetus) is breech. She (the aunt) told me that no, can rotate, can even rotate on that last month and the head be at the bottom, but if it (the fetus) didn't turn you will be done operation (caesarean section), yeah!

**R: Okay, so is there perhaps any other thing that helped you?**

P: No

**R: Okay, okay why you are saying your aunt specifically?**

P: She (the aunt) is a nurse, so yeah, it was her who I could ask everything regardless of what I was feeling. Even if I may be felt dizzy, I would call her and tell her that this is happening, she would tell me what to do. If I should go to the clinic, if my feet are oedematous, she would tell me to go to the clinic or what should I do. If something is not serious, she would tell me that, no it is normal, yeah

**R: How do you feel about having an aunt who is a nurse?**

P: It is amazing, it's a blessing because it is easy to ask something from here before I go to the clinic and that once you ask something from her, she would push you to go to the clinic. If I was someone else, I would have stayed at home and take things light but with her, she encourages us that clinic guys …… yes, I am (aunt) also a nurse but there are things that I wouldn't be able to do on you, I think it's great

**R: Okay, and tell me what makes it easier to ask her?**

P: She is an open person to begin with, besides that she is a nurse, she is very open ever since we were growing up, she is an easy person to talk to. The fact that she is a nurse it makes her to be more open because it is actually her who would approach us, before we had spoken. Even about HIV things, she says something jokingly but compelling you to do it, all that, so yeah! she is an easy person to talk to.

**R: Okay, what made you to be able to cope during that process? What was it that made you to push through during that birthing process? Are there anything that you could highlight and say, these are the things that helped me to hold on?**

P: During birthing?

**R: Yes, during birthing process from that time you felt that you are in labour until you were done giving birth**

P: I think having supportive people around you are the best thing and having nurses (midwives) that are very supportive ……. the nurse (midwife) who was assisting with my birthing process shame was amazing. From the beginning up until …...because after I had come back around three there was a change of a shift and I was assisted by the nurse (midwife) who was going to assist with birthing process. She was a very

calm person, umh! I asked everything from her. Even the issue of waters that have to break, I asked her how long should I wait she was very patient. Not getting irritated, she was telling me everything that yeah, you will now have to wait umh! I think she thought I would give birth at about eight because she (the midwife) had told me to wait until eight and all that. Yeah, the right staff that is at the hospital sometimes, it is it (the staff) that help. Cause having a rude person (midwife) I was not gonna (going) to be easy, but she (the midwife) was very calm and very helpful

**R: Okay, you mentioned something about water, I am going back a little bit, you had said that there was something that was not comprehensively explained regarding waters, what was the issue?**

P: Umh! the water breakage

**R: mhi!**

P: With it (breaking of waters) I didn't know how much time I should wait, you see. For these waters to come out, at clinic they had indicated that the waters will come out but I didn't know how much it is and how long it will take and all that. I was very shocked to see like floods of water (laughing) yeah! it was something else, I didn't expect that much. I thought it would be just drops and then passes but yeah it was too much.

**R: Okay so do you think it could have helped if you knew about it prior that probably this is the estimation of waters, would it have …….**

P: I think so because I didn't know that after that water breakage you give birth nhe and that I didn't know that after that water breakage the pains become less, you see. That too I didn't know, if I knew at least, just to be informed and have a knowledge, because I think there are a lot of things that I did not know about.

**R: mhi! Okay and that how does it make you feel that a lot of things you didn't know**

P: umh! I won't say how does it make me to feel, nhe! But now that I know, I would help someone else who doesn't know, you know. Someone who is having a baby for the first time, who maybe would want to know. And explain to her on things that I know she will never know, things that I know she will never have told at the clinic, you see, yeah!

**R: Okay, you mentioned something about hours that you were not expecting ….**

P: long hours

**R: Yes**

P: umh! that was too much (laughing) cause from one a.m up until ten p.m was a lot as I said that I thought I will have labour pains and give birth, you, see? That I will have to wait and checked, how far am I now, it was a lot, people (women) need to be told that when you will have a baby you wait so much time. And it is possible to be in labour the whole day and give birth the next day. As I see things, that could have happened cause at ten it is already the evening, it could have happened that I give birth the following day. And I was also told that, you can give birth on the 25th even if you are in labour now on the 21st, that's scary (laughing), yeah. I didn't expect other things.

**R: Okay what feeling would you attach to the fact that you didn't know that the labour can last that long?**

P: Yhoo! I was scared, scary ……. like a lot cause the pain doesn't go away it isn't like at the beginning where it would come and disappear, now it's pain, pain, pain, more pain, more pain. Even if you are given ……. Cause they (the midwives) had injected me pain relief medication but it didn't help. The only thing it made, is to make me drowsy, only, you see. No, its scary shame.

**R: Okay, you are saying pain, pain, pain, what is that?**

P: (*Laughing*) yhoo! you are getting labour pains throughout, there not stopping. And that they (the pains) increase as time goes on, not that they subside as time goes on, no. You feel the pains; you find that they are on the whole abdomen, at the lower abdomen and around the waist, so yeah!

**R: So, what was your understanding now that the pains were increasing? What was going through your mind?**

**R: What did you understand about that**

P: umh! nothing actually but I asked that nurse (midwife) was helping me, that what is happening, she (the midwife) no now the baby (fetus) is descending, you see that is why you feeling more pains. I could also see also that my abdomen is flat here on top and it (the abdomen) moved to the bottom. Then she (the midwife) told me that it is

the reason why I am in so much pains and my bones (referring to pelvis) are opening up, that was what she told me. Okay, did it made any difference in terms of the way you were feeling. Umh! no, I was scared even worse cause I didn't know what to expect, you see? But it is something that I had to go through, it was a must know you see, yeah

**R: You also mentioned that you were given injection and it did not work instead made you to be drossy**

P: Yeah, it (the pain relief medication) didn't help shame the pains persisted despite the fact that it was given. It didn't help, it made me sleepy, I didn't even sleep well, it was just for few minutes then I woke up because the pain was still there.

**R: How do you feel about that the medication didn't help?**

P: For me I think, I don't know what I will say happened, there is nothing that could help cause my mother told me that there is no medication for labour (pains). If you are having labour (pains), you are having labour pains, that's all. I think when they (the midwives) are giving you that medication for pains they assume that you will sleep and don't feel much pains but maybe we are different as people. But for me it didn't do anything, I just got drowsy but the pains were persisting

**R: Okay, could you tell me how do you feel about the general preparation you received at the clinic for birthing process?**

P: That how was it?

**R: Yes, like how is your feeling if now you were to look generally, generally the preparation you received from the clinic**

P: Its nothing compared to what I went through, you see. Their (midwives) information is truly little, they (the midwives) just give you the information and then its pills, which is they (the midwives) will tell you that these are for calcium and so on. Regarding other staff, it's nothing

**R: Okay if now I were to ask you how do you feel about the quality of that preparation that you received from the ... from the clinic?**

P: It's not poor, it's not as I said that they are just playing their own role It's not poor cause they did their best, you see but its …. it's not excellent you see. Cause if it was

excellent, I could have known like everything you see and then I would prepare myself here at home, in my mind set, you see, yeah! you see

**R: Okay, why it is important for you that you prepare mind set?**

P: So that I would be so scared and shaky and all that so I could be able to accept the situation that I will be in, cause now I didn't know what will be what, what will be what. Now I had to sleep sleepless night because I didn't know what I was going to do, I didn't have deep, deep knowledge, you see? Even that one I knew from google it was not enough

**R: Okay tell me if you look at the structure as you were prepared for the birthing process, what would you say about that? How do you feel about that structure at the clinic?**

P: umh! could you please ask the question again I don't understand it

**R: That structure, look as you were attending the clinic at a particular visit and you would be educated and then you go again on your next visit and then you get educated and then you go again and get educated, if you look at that structure how do you feel about that structure followed for preparation of birthing**

P: I don't think it is enough, like the preparation they (the midwives) are giving you (us). Because I think they (the midwives) focus on the baby (fetus), checking it (the fetus), how is it, pills, HIV and that's all, you see. And those baby kick, that chart of the baby kicks, there is nothing else they do. I think it is not enough, it was supposed that at least a person (pregnant woman) receives counselling once in a while because nine months is very long, you, see? It was supposed that at least after three months ……. There is moss that thing where it would be said that a person (pregnant woman) is now in first stage (referring to first semester) and then so on. It was supposed that at least during that time there is a counselling once in a while where it would be explained that okay now the baby (fetus) will do something like this now. Like for instance you would know that …… when you at six months it should be said that nhe! you can expect premature now. But in the clinics, there is no such, they (the midwives) only check the heart beat and all that, okay how many times has it (the fetus) kicked, then they give you pills and the you go.

**R: Okay, umh! could you now tell me the role that the clinic had played in terms of preparing you for the birthing process**

P: umh! they (the midwives) ……. What did they do (*thinking expression*)? They (the midwives) told me just (*nje-e!)* things that will happen, you, see? How old is the baby (referring to the fetus) and then what will I fee, nothing much *maan!* They (the midwives) didn't play a big role

**R: So you mean they didn't play a big role in terms of preparing you for the big day?**

P: Yeah! they didn't they just told me ... there is only one thing they had told me that was right, it's my date (referring to EDD) which is I gave birth on the 21st close to the 22nd, yeah!

**R: Okay, umh! what are the things that you think should be emphasised especially for the woman who is having a baby for the first time, when she is at the clinic. So that when she goes for birthing process, she would know them already**

P: Everything …… everything from step one up to this last era. People (woman) should be told that when you at certain month, okay the baby (fetus) is this big, of which they (the midwives) do that and then tell people (the woman) that at six months you can have premature (labour) and then okay. If your date had arrived okay, you will give birth but now you will have labour pains, how long will you have to wait for this ten centimetres they're talking about. And that the pains will get more and more as time passes. And that there are waters that need to break during that process, before you give birth, those are the things they (the midwives) air not explaining. They just scratch on the top, you will have pains or what, it is supposed that they do those things. Even if they do just an hour of class for people (women) who are due to give birth to say okay now, since you are about to give birth, we want to explain that this is what is happening when you are about to give birth. Not that the person (midwife) would tell you that okay at this day you will give birth, you will expect pains and that jelly thingy (mucous show) with bloody, not only that, it is supposed there are lot of things they (the pregnant women) are informed about.

**R: Okay you mentioned something about the class, why the class is important to you, why do you think is important**

P: It's much easier than consulting people (women) one-by-one. *Moss!* At the clinic you are given an appointment that at certain time you come, which is you are not the only person give ten, there would be a lot of people given appointment for ten. Which is there are people who are maybe given same time which are already nine months, combine them, okay come at ten will have tiny class before people (women) are done antenatal check-up maybe or after they (the women) had been done antenatal check-up, they should wait because the check-up takes few minutes, four minutes or less, yeah! just to do that ….. They (the woman) should be told that, something like this will happen only, not just to be told that you will give birth on certain day. I think it's quite easier cause when we many let us say there are five of us who are almost due for birthing process and then we attend this mini class so that this could be explained (birthing preparation). Each one would be able to ask question, which means we will now be able to get information from the asked questions, which is maybe I wouldn't have asked how long will I have to wait until I give birth, you see? So, the other woman may ask and it would be explained, which is she (the woman) gets information, consequently she (the woman) would also get when I ask my question.

**R: mhi! You also mentioned something now, that when you are consulted it is about three to four minutes**

P: mhi!

**R: Does it matter to you or did it matter to you the fact that you were consulted for three to four minutes? Why are you mentioning that?**

P: No I'm just saying, it didn't matter because what they are doing they finish in that …… not that they are robbing or anything, they do everything at the time is required to be done test that are mandatory, check baby's heart and all that, yeah and then, during that process there is a casual conversation about general staff, what's your baby name and all that, they finish with you.

**R: Okay, is there anything else you think it could be emphasised for the birthing process, while woman is attending at the clinic?**

P: umh! aa! (laughing) I don't know I can't think of anything

**R: Okay, and is there anything that you think we did not cover as we were speaking about preparation for the birthing that you might think it might be important ……**

P: Oh yeah! there's another thing that I also caught there in the hospital. There's a thing of baby drinking dirty water (referring to aspiration of meconium-stained liquor) whilst still in the abdomen, you, see? Which it is something we do not know; you see that I did not know it at all up until there was a time for us to be discharged. I then heard that other babies drank dirty water ... I think people (the women) should be told that why did their babies drank the dirty water, where is that dirty water, like where did they come about cause even them were clue less hat what had happened all that, I wish it could be explained to the people (women) that if their babies had drunk the dirty waters, whichever way they (the midwives) are explaining it. The baby (new born) will have to be checked the sugar (haemoglucose) and all that, yeah. I think people (women) should be educated about that

**R: Okay, why it is important to you that they informed prior about the sugar and that when the baby happen to drink the dirty water …**

P: The fact that the doctor is called if that had happened that means it is dangerous. I think it is needed that people are informed cause the fact that doctor is being called while the nurses (midwives) are there that means there's a danger. There is something that could have happened to your baby, you see. Yet if it was said at the very beginning that something would happen maybe she would have… After been told after giving birth you would be shocked and be like oh! there is something wrong that will happen to my baby, you see, yeah

**R: Okay, you are saying the also at some point were not able to explain it, who are you referring to?**

P: No, the nurses (midwives) didn't explain further, what exactly happened they just told them (the women) that they (the babies) drank dirty water, you see? And then we were questioning our self that what could have happened because according to our understanding, the water it is referred to it the water that comes out. And which came out and now where could other water have come from but they (the midwives) did not explain anything

**R: Okay, is there anything else that you think it can contribute to this interview**

P: umh! No. There's just a little thing that ... people (the women) must be told that they should breastfeed the new born, you, see? I something that I learned there, that you should breastfeed the baby in the first hour after giving birth. And that if you don't breastfeed it will be picked up on the sugar levels as there if a heel thingy (prick) that is done, yeah nothing

**R: You saying those things should be said prior?**

P: Yeah, because typical person would think *yeah! wethu!* I am not going to breastfeed any baby. Yet she knows that it will affect the health of the baby, you see. Cause should it is discovered that the baby is not breastfeeding and the sugar level is low, she (the woman) will not be discharged from the hospital, she will stay. And if the person (woman) is told that do this and this, a person (woman) would do that

**R: Okay, are you sure there's nothing more you want to say, is it …**

P: Ha.a! (meaning no) (*laughing*)

**R: Okay, thank you very much Miss O and I am wishing all the best with the small one**

P: Oh! thank you