ORIGINAL RESEARCH ARTICLE

Midwives' experiences regarding adverse events in obstetric units of the selected district of Gauteng province, South Africa

DOI: 10.29063/ajrh2024/v28i10.2

Rebotile V. Morobe, Thifhelimbilu I. Ramavhoya and Mamare A. Bopape*

Department of Nursing Science, University of Limpopo, South Africa.

***For Correspondence:** Email: *irene.ramavhoya@ul.ac.za*; Phone: +2715 268 3966/ +2782 221 4861

Abstract

Adverse events are a global challenge and the leading cause of litigation in the world. In the current study, a qualitative, exploratory, and descriptive design was used to explore and describe the experiences of midwives in relation to adverse events that occurred in the obstetric units of the selected district of Gauteng province, South Africa. Non-probability purposeful sampling was used to select 25 midwives who work in obstetric units in the selected district of Gauteng Province, South Africa, In-depth face-to-face interviews were conducted with each participant at their workplace. Tesch method was used to analyse the data. Measures to ensure the trustworthiness of the study were observed. The study results revealed that midwives experienced a lack of recognition and acknowledgment of their efforts; poor support and unequal opportunities; blame, litigation, and psychological effects due to adverse events. The failure to recognize, acknowledge, and support midwives during an adverse event had a detrimental effect on productivity and affected the quality of maternal health care. For midwives to provide maternal health care services effectively regardless of an AE, adequate support, effective communication, and referral for appropriate counseling were recommended. *(Afr J Reprod Health 2024; 28 [10]: 17-27).*

Keywords: Adverse event; midwives; obstetric units, support

Résumé

Les événements indésirables constituent un défi mondial et la principale cause de litiges dans le monde. Dans la présente étude, une conception qualitative, exploratoire et descriptive a été utilisée pour explorer et décrire les expériences des sages-femmes en relation avec les événements indésirables survenus dans les unités d'obstétrique du district sélectionné de la province de Gauteng, en Afrique du Sud. Un échantillonnage ciblé non probabiliste a été utilisé pour sélectionner 25 sages-femmes travaillant dans des unités d'obstétrique du district sélectionné de la province de Gauteng, en Afrique du Sud. Des entretiens approfondis en face-à-face ont été menés avec chaque participante sur son lieu de travail. La méthode Tesch a été utilisée pour analyser les données. Des mesures visant à garantir la fiabilité de l'étude ont été observées. Les résultats de l'étude ont révélé que les sages-femmes souffraient d'un manque de reconnaissance et de reconnaissance de leurs efforts ; un soutien médiocre et des opportunités inégales ; blâme, litige et effets psychologiques dus aux événements indésirables. Le fait de ne pas reconnaître, reconnaître et soutenir les sages-femmes lors d'un événement indésirable a eu un effet néfaste sur la productivité et a affecté la qualité des soins de santé maternelle. Pour que les sages-femmes puissent fournir efficacement des services de soins de santé maternelle, quel que soit un EI, un soutien adéquat, une communication efficace et une orientation vers des conseils appropriés ont été recommandés. *(Afr J Reprod Health 2024; 28 [10]: 17-27).*

Mots-clés: Événement indésirable ; les sages-femmes ; unités d'obstétrique, soutien

Introduction

Adverse events (AE) such as maternal deaths and fresh stillbirths are a global challenge, reported daily in international and national media[1]. AEs occur throughout the world, with the United States of America (USA) having the highest maternal mortality rate among developed countries[2]. AEs also occur in obstetric units in both private and public hospitals.

An AE is an unintentional event that is harmful to the patient and the service provider, occurring mostly during the delivery of health care services[1]. Public hospitals face enormous challenges that negatively impact the quality of the service provided by midwives in obstetric units. Challenges include poor working conditions in public hospitals that have been attributed to factors such as budget constraints[3]. Gauteng's public hospitals are no exception, as they have been under public scrutiny

for many years. AEs are classified as severe, moderate, and mild[3]. Severe are those that are life-threatening and cause death, while moderate are those that cause disability, incapacitation, and prolongation.

Some AEs are due to the actions of midwives and the health care system, aggravated by the shortage of maternity workers, which is a global challenge. AE can result from obstetric emergencies that are not anticipated most of the time, for example, postpartum haemorrhage and eclampsia, both of which can be prevented by proper screening, and their complications can be prevented if the woman is managed correctly[4]. However, Syed[5] stated that some are not preventable, such as placental abruption, placenta previa, shoulder dystocia, and stillbirth. Whether preventable or not, obstetric conditions are the main causes of maternal mortality. According to Coomarasamy et al[1] 94% of maternal deaths occur in low-middle-income countries with sub-Saharan Africa (SSA) and Asia bearing 86% of the total global burden. Southern Asia recorded 58,000 maternal deaths, which is one fifth of total maternal mortality; most of these deaths, 94%, occurred in low-resource settings in the care of midwives[1]. The disproportionate burden of maternal deaths that occurs in SSA is of greater concern. The region alone carries 68% of the global burden, even though it is home to only 15.7% of the world's population[6]. In Nigeria, Ope[7] concurred that AEs are associated with a high prevalence of maternal deaths due to inequalities in access to healthcare services, as women in poorly resourced settings are unlikely to receive adequate, timely, and affordable care. AEs occur in all parts of the world, and South Africa (SA) is not immune; the '*The Status of Women's Health'* in the country by Lalthapersad-Pillay[8], indicated progress in the maternal mortality ratio (MMR). As such, the ratio has decreased nationally from 105.9 deaths per 100,000 live births in 2019 to 88 deaths in 2020. The Western Cape province recorded the lowest number of deaths with 43.6 deaths per 100,000 live births. The mission of the National Department of Health (NDoH) in SA is to improve the health status of the community, prevent ill health, provide service, and ensure that AEs are reduced.

SA is the second largest area in Africa after Nigeria, with a population of 58 million residing in nine provinces. Gauteng province (GP) has become a multicultural area with a diverse population and the largest in terms of population. The health system in this province, including the district where the study was conducted, is under pressure and midwives are under the strain of providing care, which exposes them to AE. As indicated in the SA statistics, between 2020-2022, 259 AEs were reported in the three hospitals where this study was conducted[10]. The high number of AEs is exacerbated by an influx of people entering from various provinces and countries. However, midwives have an important role to play in providing quality nursing care, and this study was conducted to explore the experiences of those who had experienced AEs in the selected GP district.

Methods

A qualitative exploratory descriptive design was chosen[11] as appropriate, allowing the researcher to engage with the participants. The design allowed the researcher to explore and describe the experiences of midwives regarding AEs in obstetric units of district hospitals in Tshwane, Gauteng province.

Study setting

This study was carried out in the Tshwane district, Gauteng province, South Africa. Gauteng province, which is the economic hub, has 3 metro cities, Ekurhuleni, Johannesburg, and Tshwane.The Tshwane district consists of three academic hospitals (Dr George Mukhari, Steve Biko, and Kalafong) with a population of 12.27 million people of mixed diversity. Different languages are spoken in the district, which are isiXhosa, isiZulu, Sepedi, Sesotho, Setswana, Tshivenda, Xitsonga, English, and Afrikaans. In addition to these, there are other languages spoken by people from foreign countries who reside and use health care services in the same district. Therefore, the researcher conducted the study in obstetric units in the Tshwane district. These hospitals were chosen because of the higher number of AEs compared to the larger hospitals in the same province.

The selected settings offer antenatal services, intrapartum, postnatal care, and immunization. The three selected facilities have a total delivery rate of 40 mothers per day.

Population and sampling

The population consisted of all midwives who worked in public hospitals in the Tshwane district of Gauteng province. A purposeful non-probability sampling was used to select the 25 participants from the three (3) purposefully selected hospitals. This method was chosen because the selected participants had experienced AE during their service of care.

Inclusion and exclusion criteria

The selection of participants was based on their ability to provide rich information on the phenomenon studied[11]. Participants who had experienced AE and were more than two years in obstetric units were included in the study. Participants who were working during the night, on leave or off duty and those who were busy helping women deliver their babies during data collection were excluded from the study. This facilitated the selection of participants by their ability to provide richly textured information, relevant to the phenomenon under investigation, where all participants must have experienced the same phenomenon under study[4].

Pilot study

A pilot study is a test conducted on a trial basis in preparation for the major study[12]. A pilot study is conducted to refine, evaluate and adjust the research tools prior to data collection[13]. The researcher conducted the pilot study with a sample of two (02) registered midwives who had homogeneous characteristics with the study population. The participants used in the pilot study and the results of the collected data were not included in the main study because the research instrument was adjusted in terms of framing questions and time.

Data collection

Before data collection, permission was requested from the three (3) selected facilities in the Tshwane district. These facilities were identified because they had a higher number of AEs compared to academic hospitals.

The data collection process was carried out once permission was granted by the Tshwane district in Gauteng province. Midwives from selected public hospitals were recruited by sending them letters containing all the details of the study. A semi-structured interview guide was used which allowed for probing of questions. Participants signed consent forms before participating in the study. They were informed that they could withdraw without any consequences if they were uncomfortable. Data collection was collected in a private room at their workplace and was based on this research question '*What were your experiences when faced with an AE during the provision of maternal health care services'?* This was followed by probing questions based on the responses of the participants. Field notes were taken during the process on the behaviours of the participants. Data were collected until data saturation was reached by the twenty-third (23) participants, but two (2) more participants were interviewed to confirm saturation. The interviews lasted for 30-40 minutes; Data collection lasted for a period of six weeks.

Data analysis

Data analysis in qualitative research occurs simultaneously with data collection. Participants narrated their experiences, which were recorded and transcribed verbatim in preparation for data analysis[12]. The Tesch inductive method was used to analyse the data[11]. The researcher had to read and understand the entire script, writing down the themes that emerged. The abbreviation of the themes resulted in codes that were grouped. The themes belonging to each other were coded and grouped according to the identified experiences[9]. The eight steps were appropriate, as they helped the researcher identify the categories. A consensus was reached with the independent coder on themes and subthemes with respect to the findings.

Ethical considerations

Ethical clearance was obtained from the Research and Ethics Committee of the University of Limpopo (MREC). The permission to conduct research in the OUs of the Tshwane District was the District Ethics Committee after the ethical clearance certificate

from the University of Limpopo Faculty of Health Sciences Ethics Committee (ethical clearance number TREC 0310111-031) was submitted. Participants voluntarily signed consent forms and were aware that they could withdraw from the study if they felt uncomfortable without consequences. Participants were assured that their information would remain confidential.

Trustworthiness

To verify the trustworthiness of the research, the criteria described by Ali et al[14] as cited by Polit et al[12] namely credibility, transferability, dependability, and confirmability, were ensured. Credibility was achieved through purposive sampling, data saturation, spending two months in the field with participants, which is called prolonged engagement, triangulation, and member verification, which was done by taking the transcribed data to some of the participants to validate what was documented. Confirmability and dependability were achieved through transparency of the methodology method and analysis of data findings. Transferability was ensured by explaining in depth the methods used for data collection until data saturation. The researcher reserved bias that ensured the dependability of the collected data since the participants were confident in their statements. The same research question was used for all participants to show how applicable and transferable the findings were in different contexts [15]. The study results were consistent with the confirmation of the participant data and were supported through the literature to confirm the audit trail when the themes were formulated

Results

Table 1 indicates data collected from 25 midwives at 3 public hospitals in the Tshwane district. The presentation of the data indicated that most of the participants were black 23 and 2 white in the race column.

The age selection indicated that most of the participants in number 11 were between 27 and 42 years old, with 9 who were between 43 and 58 years old, and 5 from 59 years and older. The level of education section indicated that most of the participants had basic nursing qualifications, 4 with post-basic nursing qualifications, and only 8 had other degrees.

Presentation of themes and subthemes

Two themes with eight subthemes emerged, as depicted in Table 2.

Theme 1: Midwives related their experiences leading to AEs.

Table 2 indicates that participants experienced a lack of recognition and acknowledgement of their efforts by their managers when an AE occurred. Their work environment was not conducive, as it was influenced by the staff shortage that led to work pressure, burnout, and stress. The language barrier was another challenge that played an important role in AEs that were influenced by the diversity of the population served in the public hospitals of Tshwane District. Participants verbalised that work-centred was preferred over their health, which further led to psychological stress as they were not given time off after experiencing an AE.

Sub-theme1.1: Lack of recognition and acknowledgement.

Recognition increases morale and job satisfaction. Recognised employees would feel valued and satisfied with performing their work. In this study, participants who had better qualifications were not recognised even though their expertise was used in the provision of maternal health care services**.** Their voices are not heard, as confirmed by the following quotes:

'During *M and M meetings, everything is one-sided, doctor's issues are addressed, as midwives who are always on the patient, our concerns are not even looked at, no one is interested in your emotions, their main question is based on 'What did you do', they complain all the time that we don't do a good job, no encouragement is given'.(Participant 2)*

Another said: *When there are AEs, even the CEO comes to the ward, not to get information from our sides, when the CEO unceremoniously comes to the ward, it* means *there are serious allegations, or you know someone is guilty or something is happening otherwise no friendly visits."(Participant 8)*

Table 1: Demographic data table of participants

Race	Age	Experience	Level of education
Black =23	27-42=11	1-3years=4	Mid Diploma=13
White =2	43-58=9	4-6=12	Advanced=4
	50 and above=5	10 years and older = 9	Degree=8
Total =25	25	25	25

Table 2: Experiences of midwives who experienced AEs

THEMES	SUB-THEMES
1. Midwives related their Experiences which lead to AEs	1.1 Lack of recognition and acknowledgement
	1.2 Unconducive working environment, staff shortage
	1.3 Language barrier
	1.4Work pressure, stress, and burnout
	1.5 Work-centred vs person-centred
2. Experienced consequences of AEs	2.1 Blaming and Punitive Approach
	2.2 Psychosocial consequences
	2.3 Litigation and Misconduct Cases

*'It is painful to do your best and not being appreciated, we deliver more than forty mothers a day, we work like slaves but without recognition.' (*Participant *6)*

It was evident from these subthemes that there was a lack of recognition of the participants and the efforts made to improve care were not acknowledged. Management visits were seen as a fear for them, as these visits were not often in the units.

Sub-theme 1.2: Unconducive working environment and staff shortage

The shortage of personnel in public hospitals was cited as a major challenge by participants in overpopulated facilities. Staff shortages and an unconducive environment caused frustration, as participants were demotivated to work in overcrowded obstetric units.

The participant said: People get tired and simply drop out of work, leading to overwork and burnout. Even if you feel for your colleagues, you become mentally and physically exhausted if you have no choice but to be absent. (Participant 19)

Another participant added*: "It's just not fair to have two midwives on the ward, especially in the afternoon on these overcrowded wards our profession is at risk if we were well-staffed, I wouldn't mind but when you have two professional nurses on the ward it's risky and anything can happen and you'll be blamed." (Participant 16)*

'A *midwife goes to receive a Caesarean section baby in the theatre alone without the presence of a paediatrician with an indication of foetal distress you have to run from the theatre to resuscitate the baby in the ward, I don't know if they are afraid of paediatricians you are told to observe the baby instead of taking the baby directly to the neonatal ICU if the baby dies it's your responsibility. The working conditions here are just not suitable, remember that you are not an ICU nurse, yet you must do all these, I am not happy I need a better working place. Even after hours I mean after 16h00 you struggle to get a doctor to come check on a baby we work by God's grace and our epaulets are hanging in the air ka nnete (meaning truth)". (Participant* 9)

Some of the participants mentioned organisational problems such as poor working conditions. The participants admitted that they had no choice when tired, but to be away from work, contributing to the staff shortage. Unsuitable working conditions were raised as putting them at risk when they sometimes had to work outside their scope of practice.

Sub-theme 1.3 Language barrier

Communication between healthcare providers and patients presents a challenge in the delivery of care. Some patients could not communicate in English

and did not understand the dominant language used in hospitals, which made it difficult for midwives to provide adequate maternal health services. This was confirmed by the following quotations:

We have people from other countries who are admitted to our hospital, there is overcrowding, and the language barrier is another obstacle. How do you deliver a woman who cannot hear your instructions?' (Participant 16)

'Our district hospital is in an overpopulated area where health services are not paid for, so everyone comes for free services, people from Zimbabwe come here in the advanced stage of pregnancy, unbooked, putting us at risk and they speak the Shona language that we do not know and understand that we cannot communicate even during emergencies, making our lives difficult.'(Participant 20)

'Health education as a priority for our patients, especially during antenatal clinic classes, is hampered because most of our mothers are foreign, we even have a woman from Sudan who had female genital mutilation, where we had to prepare her for Caesarean Section for Cephalo Pelvic Disproportion she had no interpreter we had to insert a catheter because of the language barrier we could not insert it because she also resisted, but at the end we forced, which was against our ethical behaviour, such things demoralize us in this profession, you start thinking what if they take legal action?' (Participant 11)

The participants revealed the difficulty they face when carrying out a delivery of a foreign mother who needs interpretation. Language barriers prevented participants from even conveying important information to their patients, creating a risk of poor care.

Sub-theme 1.4: Work pressure, stress, and burnout

Work pressure is associated with an urge to complete work-related tasks in a specific period with acceptable levels or criteria to be met. Participants mentioned that the high physical and mental demands placed on them by their working conditions are continuously subjecting them to stressful work situations, as indicated by the participants:

As a shift leader, every responsibility lies on your shoulders during a work shift because you have advanced midwifery, you are expected to have answers for everything when an AE occurs, and you are the first to answer not being considered that you worked with newly qualified inexperienced midwives. When an incident happens, everything is on you; mentally and physically you are tired, as you have to work all day and you must check junior midwives and mothers all the time. You are to supervise a room without being appreciated, I mean, no remuneration for it. (Participant 13)

Another participant said:*One of our functions as midwives is to teach mothers, during antenatal sessions pregnant women do not receive the attention they need, we rush to educate them, the queues are long, and our attention to them is very limited as midwives you do not have the job you want to work but the pressure is too much. (Participant 11)*

You know, coming to work immediately, when you enter that gate, you ask yourself what is going to happen to you today? Who is going to blame you today? telling how incompetent you are, you are constantly in fear of losing your job, I don't feel secure, I wish I knew, but I can't wait to go on pension"(Participant 09)

Another said: *When I worked at Hospital X, there was work ethic and support, but here it is. Not even lack empathy and a negative attitude towards patients, withdraw from your colleagues, have no personal life, and develop a negative attitude toward work that once had a passion(sighing) but even then, who cares after your AEs, you are on your own". (Participant 18)*

The high levels of stress of the participants were related to factors associated with organisational issues such as poor working conditions. Participants complained about the workload experienced and felt disappointed that they could not perform their duties efficiently. Although burnout is considered an individual problem, it is associated with an occupational hazard that affects midwives' care. Burnout individuals have less productivity, which affects patient safety and quality care and exposes recipients to AEs. The statements uttered during the interviews indicated that the participants

experienced physical and emotional fatigue due to the circumstances they encountered on the job.

Subtheme 1.5 Work-centred vs. person-centred

The participants mentioned how difficult it was for them to even consult when they were not well, as they had to work considering the staff shortage. This was supported by the following statements:

'We barely *have time to be consulted when not feeling well, I mean that they cannot help you because they want to do something with this skeleton staff, our well-being is not considered here, we are the working force and cannot wait to get another job, maybe a private hospital would be better'* (*Participant 5)*

Another participant agreed, saying: You *are even expected to continue with your next tasks after delivering a fresh stillborn baby. One has been with the mother during labour when she delivers a stillborn. You are there and she expects comforting words from her midwife, but you hardly have time to be with her, another is already delivering, no manager will give you time to spend with your patient to comfort her, yours is to continue with others forgetting that as a midwife you grieve when a mother loses a baby. '* (*Participant 3)*

'No one *told us what the cause of death was, no one cares about the caregiver, there are no debriefing sessions, no emotional support we need to know if we also made mistakes to avoid them in the future, we care about our patients too, we need to close a problem that occurred when we were on duty.' (Participant 2)*

The focus on this theme was only on the outcome, not the well-being of the midwives, as they were expected to provide care no matter the circumstances in which they were located. Participants felt that even when they were prepared to work diligently, participants mentioned that they were not considered to have feelings toward their patients and the focus was only on their performance. Participants wished to be informed of the outcome of an AE if they were involved. The participants suggested that they would appreciate it if they could have some time to grieve with their patients.

Theme 2: Experienced consequences of AEs

Healthcare personnel, as employees of public hospitals, are faced with numerous challenges on their job. Consumers expect quality care; participants, on the other hand, express a culture of blame, psychological, stressful consequences, and a punitive approach by management as litigation occurs.

Subtheme 2.1: Blaming and punitive approach

The root cause of many medical errors is the lack of proper systems, protection, and support for midwives on the job. Participants feel less valuable and belittled as they are blamed for AEs as uttered by the participant.

When it came to the support situation, there was little support from management, and the interpersonal relationships between us (operational staff) and them (management) were somewhat strained as we were blamed, being told that we killed babies, we were blamed for the deaths of Klebsiella in the unit, it is painful.' (Participant 7)

The second participant confirmed the blame culture saying: 'During *M and M meetings, everything is one-sided, doctor's issues are addressed, as midwives who are always on the patient, our concerns are not even looked at, no one is interested in your emotions, their main question is 'What you did', they complain all the time that we don't do a good job, no encouragement is given'.* (*Participant 2)*

Participants were blamed which indicated poor support for midwives in the public hospitals in the selected district. Absent affirmative actions to protect midwives from inappropriate blame will increase the risk of poor professional performance and the recurrence of adverse incidents.

Subtheme 2.2: Psychosocial consequences

The feelings of the participants were reported to have been overlooked, which contributed to their psychological well-being, causing frustrations, stress, and low morale.

One participant expressed frustration by saying: As *a newly qualified midwife, I was involved in a case where a doctor performed a decapitation procedure on a baby who was stuck during delivery, the doctor left after the procedure and as a midwife I had to continue with a grieving mother, frustrated not knowing what to say, nobody understood how I felt, I was …(sigh), of that day. (Participant 18)*

A patient who came fully dilated, unbooked, accused us that we killed her baby, guess what we were to write statements about an event we were not even part of, we barely knew her status what if she had contagious diseases, we were at risk what if we were infected? (Participant 4)

'We are discouraged by the lack of support in our facility. We are still young and want to study. We envy our colleagues when you register on your own should they find out you are expelled yet you cannot be offered study leave'. (Participant 19)

This theme demonstrates the frustration and neglect of the feelings of midwives even in situations that do not directly affect them, but because they are in the same environment. The participants felt a lack of support for their plans, as they were stifled by the rules of the facilities. Some participants felt disgruntled and ignored, attended to patients, were not sure of their status, and had to explain mishaps in which they were not involved, indicating a lack of care by management.

Subtheme 2.3 Litigation and misconduct cases

The participants in this study mentioned that the causes of AEs came from poor working conditions in public hospitals, leading to litigations and putting the participant's profession at risk. This is evident in the following quotes:

"People don't *want to work in maternity wards due to these incidents that occur in the wards and their litigations, but who must do it? When you choose where you want to work, they say you will be comfortable. '* (*Participant 1)*

One participant said: The *adverse events give negative publicity to the hospital, painting us midwives as bad people with negative attitudes. There is a loss of trust in the organisation by the public, the hospital becomes all over social media, think, for example, Life Esidimeni, the National government loses money* (*Participant 11)*

'We are trying our best, nowadays everyone needs money, they sue for everything. Yes. Health services are also on social media with court cases, and you can be stripped of your qualifications when SANC does not pay attention, people say nursing has gone to the 'dogs fight with the equipment our CTGs are broken,' and sometimes you have to put a woman on a continuous machine for foetal heart monitoring where you get a machine, a baby does, then you have to take care, you are seen as incompetent, it is misconduct in the opinion of someone...Huuu (sighing). (Participant 15)

This subtheme showed that the lack of trust of midwives in managers contributes to AE because they were frustrated and depressed. The participants mentioned that the projection of images of the nursing profession by the media is painful. The public attacks midwives and how the public views them and that they are no longer respected. Participants raised concerns about hospital litigations for fear of losing their profession.

Discussion

The current study explored and described the experiences of midwives regarding AEs in the obstetric units of Tshwane district, Gauteng province. From the findings of the study, participants mentioned how their selfless efforts to care for mothers were not recognised or acknowledged regardless of their specialised qualifications. Participants who had additional qualifications were not compensated financially, which demoralised them, but their capabilities and knowledge were used. This lack of recognition results in poor teamwork and demotivation of the staff. Furthermore, recognition of midwives in stressful working environments and the provision of a conducive environment could contribute to saving public hospital litigations as quality care will be provided. As such, a review conducted by[16] recommended that managers realise how organisational justice and good leadership skills toward their subordinates could improve practical commitment.

Unconducive working environment was noted from the findings of the current study. Public hospitals are not properly maintained due to overcrowding, leading to occupational hazards that affect healthcare personnel and pose a risk of infection. Poor maintenance was associated with a lack of resources, such as the Treasury finances, to cater to the number of patients admitted to the facilities. As such, one of the participants reported that there was sometimes no water and electricity in the ward and that the environment was not conducive to patients and staff. Addressing workplace issues as indicated[17]creates long-term relationships among participants and creates a conducive work environment in which support from each other is established. Nurses in the study of[18] felt that a supportive environment would help them reflect on the innate qualities they had before AE. As observed in the current study, the staff shortage was indicated as an issue leading to an unconducive working environment. Staff shortage is a global problem that is not unusual in public hospitals. The shortfall meant that work had to be distributed among the smaller number of participants available, which affected participants physically and emotionally, leading to chronic diseases[19]. Chronically ill employees added to absenteeism, resulting in 'skeleton' staff being on duty, leading to a shortage of staff[20]. Studies conducted in Malawi by[21],[22] related the exodus of staff shortage to poor management, manager approachability, and openness. As such, a study conducted in Tanzania revealed a staff shortage as a crisis that led to the shift of tasks to lower categories of staff, leading to AEs reflecting on poor management[23]. The challenge in Tanzania was curbed by incentives hence staff retention was improved[21,22].

Based on the findings of the current study, language barriers had a negative implication in healthcare delivery. A study by[14] confirmed that 50% of midwives who cared for foreign language members contributed to errors in health care. This was influenced by global migration and linguistic diversity, which are high in the Gauteng province as a hub of the economy. Midwives in overpopulated facilities faced a language barrier that needed the help of an interpreter, which had an impact on the delivery of care. A patient's language preference that differs from the official language of a country has been shown to mitigate health disparities in the way the patient's culture and the delivery or performance of clinical procedures are performed[24]. Participants in the study struggled to access interpreters and expressed distrust of how the interpretation was carried out to the recipients of care.

Participants in this study reported burnout that was exacerbated by workload, lack of resources, poor motivation, and staff shortage. This increased the stress levels of the participants, which were linked to factors associated with organisational problems, such as poor working conditions. Furthermore, the study findings revealed that the workload experienced by midwives affected their sleeping patterns, as they could not perform their duties efficiently. The findings of the current study were confirmed by[4] who defined job stress as an emotional state with spheres of sadness, grief, irritability, and depression which required psychological support. Similarly, the findings of the current study indicated a lack of operational and psychological support. Poor operational support of the participants and lack of implementation of policies hindered proper maternal health care services leading to AEs[25,26].

Participants raised concerns about psychological, physical, and cognitive fear issues since they are expected to report at work even when they are not feeling well. This gave rise to presenteeism known as employee perseverance[25]. In this study, work-centred approaches versus person-centred approaches. The lack of person-centred approaches raised fears that participants would be stripped of their profession by the South African Nursing Council (SANC) if found guilty during the occurrences of AE. As such a study conducted in the United States revealed that 85% of healthcare workers reported having worked while sick, which harmed service delivery as they did not perform their duties as expected by the employer[27].

Most of the participants described having spent many hours agonizing and wondering if they could have prevented the adverse outcome. The participants expressed a culture of blame and a punitive approach to management, which negatively affected the willingness of the participants to report errors. However, the provision of quality care is the responsibility of the participants and the expectation of the care by the consumers. Similar results were obtained from a study conducted by[28] in which participants experienced strained relations as they

were blamed and not encouraged by management after an AE. Participants indicated that they rarely receive a visit from management unless there are AEs, which is indicative of poor communication relations between them and management in public hospitals. Poor communication, as reported by the participants, characterized a lack of trust, support, and respect from the management. Participants reported how isolated they felt and treated in their work area. They felt 'belittled' in areas where they were always providing care and felt undermined as their suggestions or opinions were not expected from them. As such, support during this time is crucial for midwives to deal with the loss they have experienced[29].

The findings of the current study revealed that some causes of AEs were derived from poor working conditions in public hospitals, leading to litigation despite the hard work of midwives, putting their profession at risk. According to[30], some litigations are due to the inadequacy of midwives to perform quality care as they lack resources. The participants mentioned that the projection of images of the nursing profession in the media hurts how the public views them, as social media portrays them as negative and incompetent professionals.

Limitations

Despite the results showing the willingness of participants to improve care, there were still limitations that occurred. The study was carried out in three Tshwane district hospitals in Gauteng, and the results cannot be generalised to enrich the data

Conclusion

The current study showed that the lack of recognition and recognition of midwives' efforts and their qualifications by employers played a negative role in their performance. Language barriers, work pressure, and burnout lead to AE, which further facilitates midwife psychological stress. When an AE occurs, midwives are blamed and face litigations and misconduct cases regardless of circumstances surrounding an AE, as some were caused by a lack of human and material resources. As such, the provision of adequate material resources, recognition, acknowledgement of midwives' effort and psychological support was recommended as it could play a crucial role in reducing AEs and litigations in obstetric units.

Acknowledgments

The researcher wishes to thank the Tshwane Health District for granting permission to conduct the research in its facilities, the MOU managers who made available space in their facilities to conduct interviews, the midwives who participated in the study, and the managers.

Authors' contributions

RVM the researcher participated in data collection, analysis, conceptualization, and report writing. TIR and MAB were the promoters of the student in conducting a literature search, data collection, analysis, and finalization of the article report. We all agreed on the content of this article

Conflict of interest

None

Funding

The authors declare that financial or personal relationships do not apply to writing this article

References

1. Coomarasamy A, Williams H, Truchanowicz E, Seed PT, Small R, Quenby S, Gupta P, Dawood F, Koot YE, Atik RB, Bloemenkamp KW. PROMISE: first-trimester progesterone therapy in women with a history of unexplained recurrent miscarriages-randomized, double-blind, placebo-controlled, international multicenter trial and economic evaluation. Health technology assessment (Winchester, England). 2016 May;20(41):1.
2. World Health Organisation. World Alliance for Patient Safety draft guidelines for adverse event reporting and learning systems – from information to action. 2019, Geneva, Switzerland.
3. Facciolà A, Pellicanò GF, Visalli G, Paolucci IA, Venanzi Rullo E, Ceccarelli M, D'Aleo F, Di Pietro A, Squeri R, Nunnari G and La Fauci V. The role of the hospital environment in the healthcare-associated infections: a general review of the literature. Eur Rev Med Pharmacol Sci. 2019 Feb;23(3):1266-1278.
4. Nolte AGW, Marshall, JE, and Raynor MD. Myles Textbook for Midwives: African Edition. Johannesburg: Van Schaik. 2015
5. Attri LK, Subhash Chandra BJ, Ramesh M, Chalasani SH, Syed J and Pal N. Materiovigilance in Intensive Care Units: Active surveillance. Hospital pharmacy. 2023 Aug;58(4):382-8.

6. Tison GH, Avram R, Kuhar P, Abreau S, Marcus GM, Pletcher MJ, and Olgin JE. Worldwide effect of COVID-19 on physical activity: a descriptive study. Annals of Internal Medicine. 2020 Nov 3;173(9):767-70.
7. Ope BW. Reducing maternal mortality in Nigeria: addressing maternal health services' perception and experience. Journal of Global Health Reports. 2020 May 18;4: e2020028.
8. Lalthapersad-Pillay P. The state of maternal mortality in South Africa. Gender and behaviour. 2015 Jan 1;13(1):6471-81.
9. South Africa Census Statistics. 2019 Programme, Pretoria, South Africa. Available online: https://www.statssa.gov.za
10. Bomela NJ. Maternal mortality by socio-demographic characteristics and cause of death in South Africa: 2007–2015. BMC Public Health. 2020 Dec; 20:1-20.
11. Creswell JW and Creswell JD. *Research Design: Qualitative, Quantitative and Mixed Methods Approaches*, 5th ed.; SAGE: Thousand Oaks, CA, USA 2018
12. Polit D and Beck C. Essentials for Nursing Research: Appraising evidence for nursing practice. Lippincott Williams & Wilkins.2020
13. Bruce N, Pope D and Stanistreet D. Quantitative methods for health research: a practical interactive guide to epidemiology and statistics. John Wiley & Sons; 2018 Feb 5.
14. Ali PA and Watson R. Language barriers and their impact on the provision of care to patients with limited English proficiency: Nurses' perspectives. J Clin Nursing 2018. Mar;27(5-6): e1152-e1160. 10.1111/jocn.14204
15. Houser, J. 2018. Nursing Research Reading, Using and Creating Evidence 4th edition. Jones & Bartlett Learning
16. Dirks KT and de Jong B. Trust within the workplace: A review of two waves of research and a glimpse of the third. Annual Review of Organizational Psychology and Organizational Behavior. 2022 Jan 21; 9:247-76.
17. Biron C and Karanika-Murray M. Process evaluation for organizational stress and well-being interventions: Implications for theory, method, and practice. International Journal of Stress Management. 2014 Feb;21(1):85.
18. Malenfant S, Jaggi P and Hayden KA, Sinclair S. Compassion in healthcare: an updated scoping review of the literature. BMC palliative care. 2022 May 18;21(1):80.
19. Haddad LM, Annamaraju P and Toney-Butler TJ. Nursing Shortage. In: Stat Pearls Treasure Island (FL): Stat Pearls Publishing; 2024 Jan Available from: https://www.ncbi.nlm.nih.gov/books/NBK493175
20. Asegid A, Belachew T and Yimam, E. Factors influencing job satisfaction and anticipated turnover among nurses in Sidama Zone public health facilities. South Ethiopia. Nursing Research and Practice. 2014. http://dx.doi.org/10.1155/2014/909768.
21. Chimwaza W, Chipeta E, Ngwira A, Kamwendo F, Taulo F, Bradley S and McAuliffe E. What makes staff consider leaving the health service in Malawi? Human resources for health. 2014 Dec; 12:1-9.
22. Chipeta E, Bradley S, Chimwaza-Manda W and McAuliffe E. Working relationships between obstetric care staff and their managers: a critical incident analysis. BMC health services research. 2016 Dec; 16:1-9.
23. Munga MA, Torsvik G and Mæstad O. Using incentives to attract nurses to remote areas of Tanzania: a contingent valuation study. *Health policy and planning*, 2014.*29*(2), pp.227-236
24. Gerchow L, Burka LR, Miner S and Squires A. Language barriers between nurses and patients: A scoping review. *Patient education and counseling*, 2021:*104*(3), pp.534-553.
25. Dall'Ora C, Ball J, Reinius M and Griffiths P. Burnout in nursing: a theoretical review. *Human resources for health*, 2020. *18*. pp.1-17
26. Boivin DB, Boudreau P and Kosmadopoulos A. Disturbance of the circadian system in shift work and its health impact. Journal of biological rhythms. 2022 Feb;37(1):3-28.
27. Kigozi J, Jowett S, Lewis M, Barton P, and Coast J. The estimation and inclusion of presenteeism costs in applied economic evaluation: a systematic review. Value in Health. 2017 Mar 1;20(3):496-506.
28. Ally H, Nel E and Jacobs W. Operational managers experiences of a culture of blame following nurse-related adverse in a regional hospital in Gauteng, South Africa. Open Journal of Nursing. doi. 2016;10.
29. Jones IH, Thompson A, Dunlop CL and Wilson A. Midwives' and maternity support workers' perceptions of the impact of the first year of the COVID-19 pandemic on respectful maternity care in a diverse region of the UK: a qualitative study. BMJ open. 2022 Sep 1;12(9): e064731.
30. Mammbona AA and Mavhandu-Mudzusi AH. Enrolled nurses' experiences of caring for patients living with HIV in a South African rural hospital. International nursing review. 2019 Mar;66(1):139-46.