



Article

Evaluation of Midwifery Practices among Registered Midwives in Selected Hospitals in Limpopo Province, South Africa

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Abstract: Midwifery practices are defined as the level of midwifery care in which midwives use their expertise, management, and clinical leadership to provide personalized, evidence-based care to women independently and autonomously. Midwifery care includes antepartum, intrapartum, and postpartum care, which are defined by the WHO as the care provided by skilled healthcare professionals to pregnant women and adolescent girls to ensure the best health conditions for the mother and baby during the antepartum, intrapartum and postpartum period. The aim of this study was to evaluate midwifery practices among registered midwives in selected hospitals in Limpopo Province, South Africa. The quantitative, descriptive, and cross-sectional research design was used to assess and describe midwifery practices among registered midwives in selected hospitals in Limpopo Province, South Africa. The population size was 100 registered midwives in the selected hospitals. The sample size of 80 registered midwives was determined using the Slovin formula. Simple random sampling was used to select the sample. A self-developed questionnaire was tested and validated prior to conducting the main study. The findings of the pilot study were used to refine the questionnaire before being used for the main study. Reliability and validity were ensured. Data were analyzed using the Statistical Package for Social Sciences (SPSS) version 27 with the assistance of a statistician. The study revealed inadequate provision of midwifery care during antepartum, intrapartum, and postpartum periods due to lack of resources and equipment. The shortage of midwives and the shorter experience in the clinical setting within the midwifery environment were overwhelming. The study concluded that the practices of registered midwives were inadequate due to some challenges they faced during the provision of midwifery care. Inadequate midwifery practices have serious implications for the health and well-being of mothers and newborns. These practices were influenced by various factors, such as inadequate material and human resources and lack and malfunctioning of available equipment. The study recommended that women have access to a variety of pain relief options during labor, including both pharmacological and non-pharmacological methods. In addition, the study recommended implementation of the presence of doulas during labor and childbirth.

Keywords: evaluation; midwifery; practices; registered midwives



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1. Introduction

The significance of midwifery as a fundamental pillar in the healthcare of women and children cannot be overstated, as it provides a comprehensive approach that addresses the physical, emotional, and social well-being of mothers and their babies [1]. Midwives, as dedicated healthcare professionals specializing in antepartum, intrapartum, and postpartum care, play a pivotal role in improving maternal and child health outcomes. However, in Nigeria, midwives face challenges affecting midwifery practice in the region, which include usurping of midwives' roles by doctors, lack of comprehensive data on midwives, poor attitude of midwives, poor remuneration, negative patient perceptions of midwives, and lack of resources and equipment [2]. Midwifery practices have evolved in response to

the increasing complexity of healthcare demands, characterized by operational pressures and the imperative for cost-effective, continuous, and accessible healthcare. The adaptability of midwives to rapidly changing healthcare settings is crucial for the delivery of quality midwifery care [3]. As an alternative to mandated legislated standards, midwifery practices serve as a means of maintaining and improving quality, offering a platform for self-assessment and benchmarking. Given the dynamic and evolving nature of midwifery care, continuous professional development, particularly in essential areas, such as the management of obstetric emergencies, is imperative to maintain clinical expertise [4,5].

The evaluation of midwifery practices is guided by policies and guidelines that define the profession. The World Health Organization (WHO) describes antepartum care as a comprehensive approach provided by skilled healthcare professionals to ensure optimal health conditions for pregnant women and adolescent girls. This includes the identification, prevention, and management of the risk of pregnancy-related conditions, health education, and promotion [6]. Monitoring fetal well-being during the antepartum period using various tools, such as the non-stress test (NST) and antepartum classes, becomes crucial to improving midwifery care and outcomes. Antepartum care spans from conception to the onset of labor, focusing on monitoring the health of both the mother and the fetus to promote a healthy pregnancy and reduce complications [2]. The South African Guidelines for Maternity Care emphasize the importance of antenatal care in ensuring the best possible pregnancy outcomes through risk screening, assessment, treatment, and education [7].

Intrapartum care encompasses the various stages of labor, including monitoring progress, communication, informed consent, and appropriate clinical interventions when necessary. Midwifery practices during the intrapartum period, as outlined in the guidelines, include respecting privacy, companionship during labor, dietary considerations, mobility, and the use of technologies, such as Cardiotocograph (CTG) machines and Partogram [7,8]. Postpartum care extends from immediately after birth to six weeks and focuses on the physical recovery of the mother, the emotional well-being of both the mother and the baby, and the establishment of breastfeeding and parenting routines.

Despite its importance, postpartum care is often neglected, emphasizing the need for comprehensive follow-up and support during this critical period [8]. Lack of education, poverty, and limited access to healthcare facilities contribute to low utilization of postpartum care, highlighting the importance of education and accessible healthcare in supporting the well-being of mothers and newborns [6].

The implementation of evidence-based practices is crucial in ensuring positive outcomes in childbirth. The birth environment, including professional support, work relationships, workload, and equipment, significantly impacts birth experiences [9]. Failures in service provision, as identified in studies conducted in Ireland, underscore the importance of addressing challenges during birth to improve confidence in maternity services [10].

Despite global efforts, complications, such as bleeding, infections, and high blood pressure, still pose risks during delivery. Skilled care at birth is essential to prevent mortality, and initiatives, such as the Safe Childbirth Checklist, aim to ensure essential care practices worldwide [8]. However, challenges persist, such as the shortage of midwives, leading to overwhelming workloads and compromising quality of care, leading to a higher rate of home deliveries [11]. This study evaluated midwifery practices to identify areas of strength and weakness in midwifery practice, allowing for targeted quality improvement initiatives. By evaluating current practices, healthcare providers can implement evidence-based interventions to enhance the quality of care provided to pregnant women and newborns.

2. Materials and Methods

In this study, the quantitative research method was used to collect data that were measured and numerically summarized. A research design is defined as a blueprint for conducting research [12,13]. A descriptive cross-sectional research design was used to evaluate midwifery practices among registered midwives

2.1. Study Site

The study was carried out in selected hospitals in Limpopo Province, South Africa. The selected hospitals are public hospitals governed by the Limpopo Department of Health. In both hospitals, services are free for pregnant and breastfeeding women, as well as children under the age of six. They have maternity units in which midwifery care is provided to women during the intrapartum, antepartum, and postpartum periods. On Wednesdays and Tuesdays every week, the hospitals conduct high-risk clinics for pregnant women who are attended to by registered midwives and doctors working in the antenatal clinic. These hospitals were selected because they offer midwifery care and also because of the high volume of pregnant and laboring women they admit.

2.2. Population and Sampling

The target population was all registered midwives assigned to the maternity units of the two selected hospitals in Limpopo Province. Respondents were appropriate for this study as they practice midwifery during the antepartum, intrapartum, and postpartum periods. The Slovin formula was used to calculate the sample size of 80 midwives out of the population of 100 participants. Slovin's formula ($n = (N)/(1 + Ne^2)$) is used to calculate the sample size (n) given the population size (N), which is 100, and the margin of error (e), which is 0.05. It is a random sampling technique formula to estimate the sample size [14]. Simple random sampling was used to select participants who were interested in participating.

2.3. Data Collection

After the study was ethically cleared (TREC/61/2021:PG) and permission was obtained by the Limpopo Department of Health and the management of the selected hospitals, the principal researcher prepared for the data collection process. The questionnaire was developed after carefully reviewing the literature and validated with Cronbach's alpha with internal consistency of $\alpha < 0.686$. The final questionnaire was presented to the supervisor, co-supervisor, and data statistician and restructured according to the study objectives. The researcher visited the study sites to recruit the respondents to participate in this study. The researchers briefed the respondents about the purpose of the study before distributing questionnaires for the pilot study [15].

The questionnaire was piloted with 5 respondents to assess the readability of the questions and the ability of the respondents to understand and answer the questions. Some questions underwent minor changes after the pilot study, and the findings from the pilot study were not incorporated into the main study. The principal author collected data from September to November 2021 using a self-administered questionnaire. Eighty questionnaires were distributed among the respondents, and the items on the questionnaires were divided into two sections. The questionnaire sections included Section A: Demographic data, which comprises 5 questions, and Section B: Evaluation of midwifery practices, which comprises 12 questions. Thus, the total questions were 15. The questionnaire utilized a Likert scale with the options Always (A), Frequently (F), Occasionally (O), Seldom (S), and Never (N). The questionnaires consisted of closed-ended questions that were also completed autonomously in the study. The questionnaire was sent by the principal researcher to both hospitals. Verbal consent was obtained voluntarily from each respondent before participating in the study. Written informed consent was obtained by asking the respondents to sign the consent form. Respondents were informed that their participation in the study was voluntary [16]. The duration of completion of the questionnaire was approximately 30–40 min. In addition, an additional 10 min were granted to those who could not finish in 40 min.

2.4. Data Analysis

Data analysis is the systematic organization and synthesis of research data [17]. The completed questionnaires were coded, this allowed the researcher to easily identify them

for filling in any missing data. Data were analyzed using the Statistical Package for Social Sciences (SPSS) version 27 with the assistance of the statistician. Descriptive statistics were used to analyze the data. Descriptive statistics is a form of statistical analysis that organizes and summarizes the collected data in the form of graphs, percentages, and averages [18]. The data were presented in the form of bar graphs and tables. In this study, midwifery practices were assessed to establish how they affect registered midwives and patient care.

3. Presentation and Discussion of the Results

The results of the study are presented and discussed according to the sections of the questionnaire. Descriptive statistics, such as frequencies and percentages, were used for closed-ended questions.

3.1. Presentation of the Results

Eighty questionnaires were distributed to the respondents, and only seventy were completed and returned; however, four were spoiled because they were incomplete, and seventeen were not returned. Therefore, a total of forty-nine questionnaires were analyzed, and data were presented in the form of tables and figures, frequencies, and percentages; therefore, the response rate was 70%.

3.2. Section A: Demographic Data of the Respondents

The demographic data include age, gender, qualification, and years of experience, and they are presented as follows.

Figure 1 indicates the age of the registered midwives who participated in the study. This suggests that a significant portion of the registered midwives involved in the study were aged 50 and above, with the next largest age group being between 22 and 35 years old.

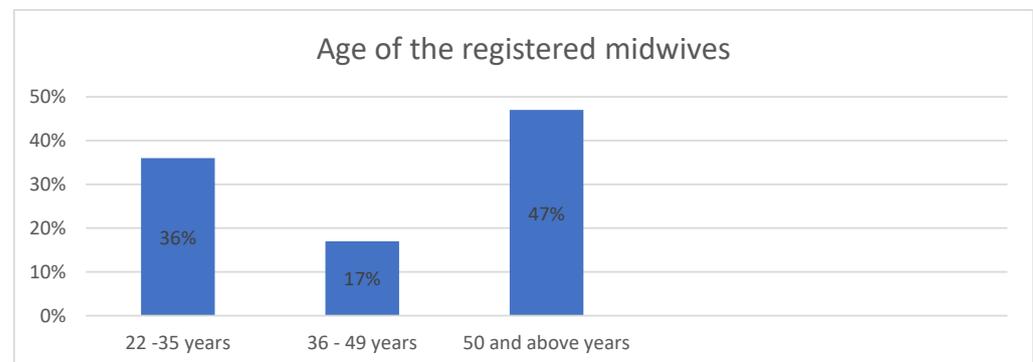


Figure 1. Age of registered midwives n = 49.

The results depicted in Figure 2 reveal that among the registered midwives in the sampled hospitals, the majority are women, with only a minority being men. This suggests that nursing and midwifery tend to be professions predominantly occupied by females and that most men may not feel at ease in maternity units.

Figure 3 shows that the majority (82%) of the midwives who participated in the study possessed midwifery qualifications without a speciality. This implies that although the advanced midwifery specialty is critical for midwifery care, most of the midwives are practicing without an additional midwifery qualification.

Figure 4 indicates that 41% of the respondents had 2–5 years, 37% had 6–10 years, 16% had 11–15 years, and 6% had more than 15 years of experience working in the maternity unit. The results revealed that most of the respondents had less than 6 years of experience in the maternity unit and a minority had more than 5 years of clinical experience.

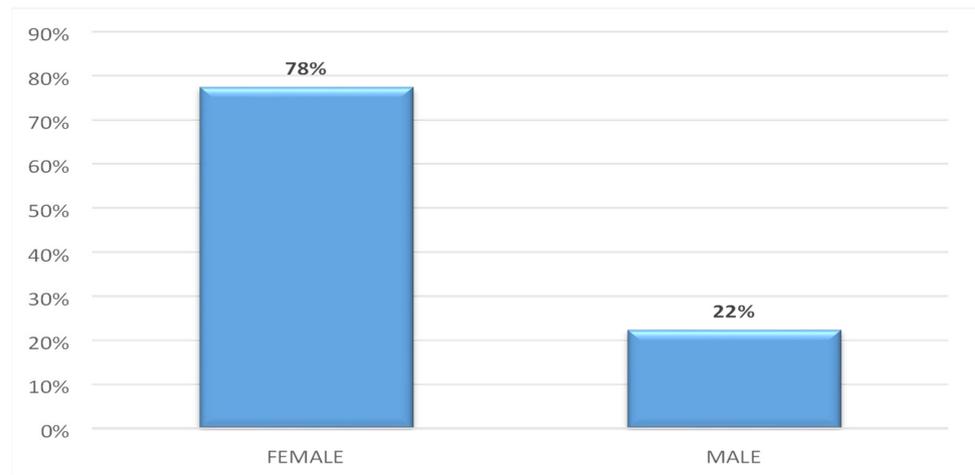


Figure 2. Indicates the gender of the registered midwives who participated in the study.

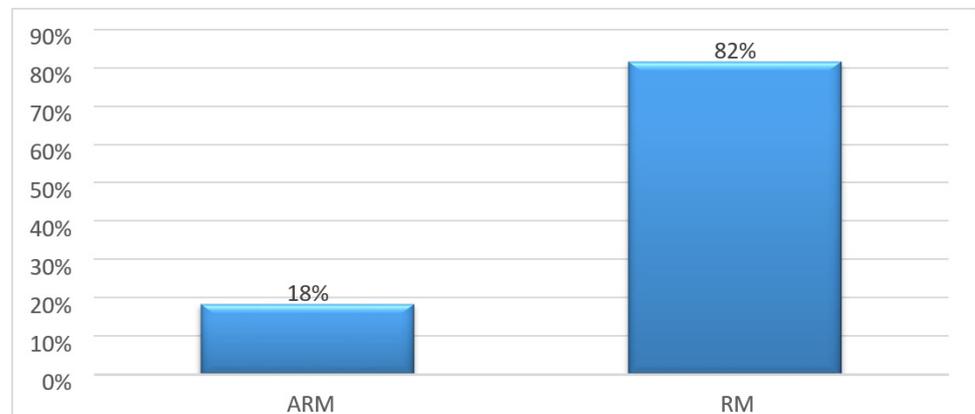


Figure 3. Qualifications of the registered midwives who were allocated to maternity units.

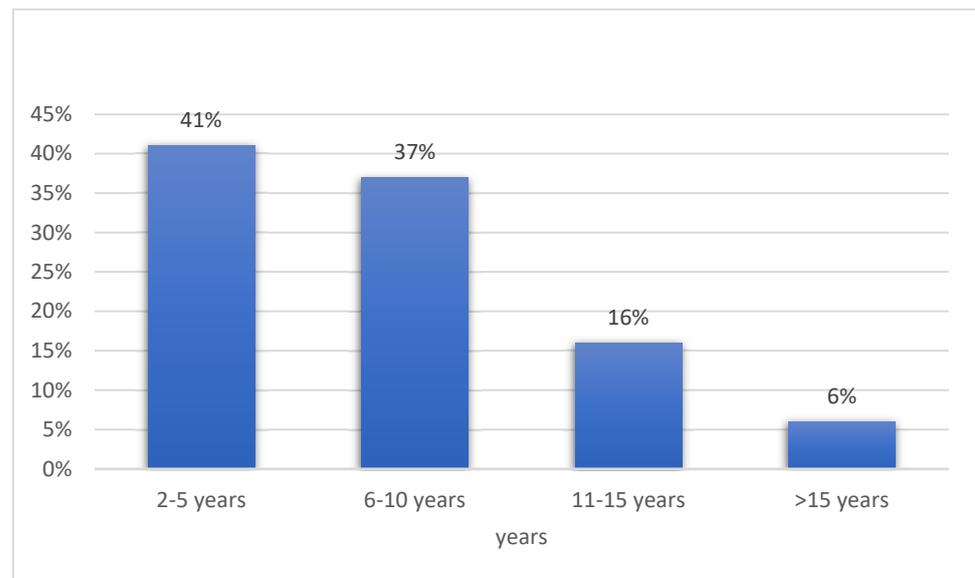


Figure 4. The years of experience of the respondents in maternity units.

3.3. Section B: Evaluation of Midwifery Practices

Table 1 shows the summary of responses to the evaluation of midwifery practices. Always and frequently were regarded as positive responses, while never, seldom, and occasionally were regarded as negative responses.

Table 1. Midwifery practices.

Midwifery Practices	A	F	O	S	N
	% (n)				
Antepartum Care					
Are pregnant women provided with emotional support during antepartum care?	38 (77.6%)	8 (16.3%)	2 (4.1%)	1 (2.1%)	0 (0%)
Do you address questions and concerns of pregnant women during antepartum care?	29 (59.2%)	11 (22.4%)	7 (14.3%)	2 (4.1%)	0 (0%)
Do you monitor the fetal and maternal well-being during high-risk antenatal visits?	33 (67.3%)	13 (26.5%)	3 (6.1%)	0(0%)	0(0%)
Intrapartum Care					
Are women provided with emotional support during labour and delivery?	25 (51.0%)	17 (34.7%)	7 (14.3%)	0 (0%)	0 (0%)
Are pregnant women advised to bring doulas during labour and childbirth for support?	0 (0%)	0 (0%)	0 (0%)	1 (2.1%)	48 (97.9%)
Are pregnant women given pharmacological pain relief during labour?	31 (63.3%)	11 (22.4%)	5 (10.2%)	2 (4.1%)	0 (0%)
Is the care given to women during labour and childbirth appropriate?	29 (59.2%)	11 (22.4%)	7 (14.3%)	2 (4.1%)	0 (0%)
Is the documentation in the books such as Partogram and admission books done?	10 (20.4%)	21 (42.9%)	4 (8.2%)	5 (10.2%)	9 (18.9%)
Postpartum Care					
Do you provide health education to mothers during the postpartum period?	29 (59.2%)	11 (22.4%)	7 (14.3%)	2 (4.1%)	0 (0%)
Do you support mothers in early initiation of breastfeeding	10 (20.4%)	11 (22.4%)	10 (20.4%)	12 (24.5%)	6 (12.2%)
Do you promptly address complications during the postpartum period, e.g., signs of postpartum haemorrhage?	19 (38.8%)	12 (24.5%)	10 (20.4%)	4 (8.2%)	4 (8.2%)

According to the information presented in Table 1, 46 (93.3%) of the respondents affirmed that emotional support was provided consistently and frequently to women during antenatal care, with approximately 3 (6.2%) expressing disagreement with the provision of emotional support to pregnant women. Regarding the response to the questions and concerns of pregnant women, 81.6% of the respondents consistently and frequently addressed these adequately, while 14.3% indicated occasional attention. Only two (4.1%) of the respondents mentioned infrequently addressing questions and concerns, and none reported never addressing them.

Furthermore, 46 (93.8%) of the respondents confirmed their practice of monitoring both fetal and maternal well-being during high-risk antenatal visits, while roughly 3 (6.1%) acknowledged occasional monitoring. None of the respondents reported infrequent or nonexistent monitoring. In the context of labor and delivery, 42 (85.7%) of the respondents reported that women consistently and frequently receive emotional support, while approximately 7 (14.3%) mentioned occasional support. The data in Table 1 show that 0 (0%) of the respondents indicated that pregnant women were always and frequently not advised to bring doulas during labor and childbirth for support. Only 1 (2.1%) indicated that they were seldom advised, while almost all, 48 (97.9%), indicated that they never advised pregnant women to bring doulas. The data reveal that 42 (85.7%) of the respondents concluded that pregnant women were provided pain relief during labor, while 5 (10.2%) indicated occasional provision. Only two (4.1%) mentioned infrequent provision and none (0%) disagreed with the notion that pain relief was never provided. Furthermore, 40 (81.6%) of the respondents agreed that the care given to women during labor and childbirth was appropriate.

Furthermore, seven (14.3%) believed that appropriate care was provided occasionally, while only two (4.1%) mentioned infrequent appropriateness. None (0%) of the respondents disagreed with the notion that the care provided was inappropriate. About 17 (34.7%) of the respondents mentioned that they stayed with the woman consistently when the second stage of labor was imminent. About 15 (30.6%) indicated an occasional presence, while 8 (16.3%) stated an infrequent presence, and 9 (18.4%) reported never staying with the woman in such circumstances. The data reveal that 31 (63.3%) strongly agreed that record completion was performed in multiple books, while 4 (8.2%) remained neutral on the matter, and 14 (29.1%) strongly disagreed with the completion of records in multiple books.

Of the respondents, 40 (81.6%) confirmed that they provided health education to mothers during the postpartum period. The occasional and infrequent provision of health education was reported by seven (14.3%) and two (4.1%) respondents, respectively. None (0%) of the respondents disagreed with the notion that they never provided health education to mothers. As shown in Table 1, 21 (42.8%) of the respondents stated that they consistently supported mothers in the initiation and establishment of breastfeeding, while 10 (20.4%) indicated occasional support, 12 (24.5%) reported infrequent support, and approximately 6 (12.2%) stated that they never supported mothers in this regard. Furthermore, 31 (63.3%) of the respondents reported that they resolved complications promptly consistently during the postpartum period. Approximately 10 (20.4%) of the respondents indicated occasional attention to complications, while 4 (8.2%) reported infrequent attention, and the same number, 4 (8.2%), said that they never addressed complications promptly.

4. Discussion of the Findings

This study aimed to evaluate midwifery practices among registered midwives in selected hospitals in Limpopo Province, South Africa.

4.1. Demographic Information of Registered Midwives

The findings indicated that most of the respondents were older registered midwives with knowledge and skills, although they were old. Another study supports this observation, highlighting that older midwives had valuable experience but struggled with the demands of late nights, long shifts, and the physical strain of delivering and caring for babies [19]. The respondents in this study were predominantly female, with a small representation of men, reflecting the historical perception of the nursing profession as predominantly female, which may have influenced its gender distribution. This is consistent with the findings of another study, which indicated that nurses in the northwest region of South Africa reported higher job satisfaction (92.4%) compared to their male counterparts (7.6%) [20]. The nursing field has long been considered predominantly female, which likely influences its gender composition [21]. A study examining the experiences of male registered nurses undergoing clinical training in midwifery at a regional hospital in the Eastern Cape discovered that these nurses perceived midwifery as anxiety-inducing, daunting, and diminishing their confidence [22]. On the contrary, the women who participated in these studies were found to exhibit less anxiety, as midwifery is traditionally viewed as a feminine domain [23]. The results revealed that a minority of the respondents had advanced midwifery specialization, while few had basic midwifery qualifications. The lack of specialization prevented registered midwives from providing efficient and quality care, which could impact maternal health outcomes. Other studies have similarly highlighted the critical shortages of qualified staff trained specifically for maternal healthcare services in rural health facilities, such as those in Tanzania [24].

Providing midwifery services without the necessary knowledge and skills can negatively affect practice. Research has shown that lack of skills and knowledge in the field can lead to frustration, reduced motivation, and lower-quality midwifery care, thus increasing the health risks for pregnant women and newborns [25]. When registered midwives perceive a lack of knowledge or skills, it can act as a barrier to action, resulting in uncertainty about initiating or carrying out desired actions. This hesitation or avoidance may contribute

to poor-quality midwifery care services [26]. Most registered midwives had less than five years of experience in the maternity unit, with only a minority having more than five years of clinical experience. Research suggests that increased experience beyond 5 years correlates with an improved quality of midwifery care services for pregnant, laboring, and post-delivered women [5]. Another study found that older and more experienced midwives were more likely to provide complete labor support, including administering analgesics, providing social support, and effectively managing multiple women at the same time [19].

4.2. Evaluation of Midwifery Practices

The findings indicated that most registered midwives consistently offered emotional support to pregnant women during the antepartum period. This is consistent with a similar study that reported that the majority of registered midwives provide care to women with mental health problems, including primarily anxiety and depression [20]. Additionally, registered midwives informally assessed women's mental health by observing or asking about mood, anxiety levels, support, and mental health history. According to the Health Promotion Model (HPM), perceived self-efficacy can be improved by providing accurate and positive information, encouraging women to set achievable health goals during the antenatal period and childbirth, and empowering them to actively participate in their care and make informed decisions. Therefore, it is crucial that registered midwives undergo training in perinatal mental health to provide effective emotional support to pregnant women.

The results also revealed that almost all of the respondents consistently monitored fetal and maternal well-being during antenatal visits. The primary objective of midwifery care is to assess and prevent adverse outcomes for the fetus, the neonate, and the mother. Monitoring during the antepartum period is crucial to ensure the health and safety of both the mother and the fetus, thus allowing for early detection of complications, assessment of fetal growth and development, identification of abnormalities, management of maternal health conditions, provision of health education, and monitoring the progress of pregnancy [27]. Regular monitoring enables midwives to take the necessary actions to optimize results and promote a healthy pregnancy. This is consistent with a study that emphasizes the importance of monitoring to assess fetal and maternal well-being and early detection of fetal responses to hypoxemia.

In the intrapartum period, which can be traumatic for women in labor, providing emotional support is crucial to coping with fear of childbirth and labor pain. This study found that most registered midwives provided constant emotional support during labor and delivery. This contrasts with the findings of another study that observed limited emotional support provided by midwives during this period, as none asked about women's fears and personal preferences [28]. According to HPM, registered midwives promoted perceived self-efficacy through informational support and encouraged women to express their personal preferences. Training in intrapartum counseling skills is essential for registered midwives to effectively provide emotional support and promote the health of women and their babies [21]. Although the Better Births Initiative (BBI) standards advocate for a doula or companionship in labor as an evidence-based intervention, the current study revealed that the majority of registered midwives did not recommend women to have their doulas during labor and childbirth [23]. This finding is consistent with another study that noted a lack of encouragement from midwives with respect to the presence of a doula and the integration of cultural and personal preferences during childbirth [24]. Challenges in public settings, such as inadequate space, privacy concerns, and security, were reported as reasons why companions could not accompany laboring women, as observed by registered midwives assigned to public settings.

The labor and delivery process poses significant physical and emotional challenges for women. However, having a trusted companion on your side offers emotional support and comfort. The presence of a doula or labor companion can alleviate anxiety, fear, and feelings of isolation during labor, thus fostering a sense of security and comfort. In

contrast, a study highlighted the pivotal role that women's labor companions play, but the experiences of women varied based on the attitude of their labor companions [27]. Therefore, it is recommended that the supervisors of the unit of work allow doulas in the units to provide support to women. The Health Promotion Model (HPM) recognizes the presence and support of a birth companion or doula as a substantial situational influence during the intrapartum period and childbirth. On the other hand, interpersonal influences can profoundly shape women's beliefs, attitudes, and behaviors related to health or the labor and childbirth process. In addition, doulas' social support plays a crucial role in promoting health and well-being, including emotional, instrumental, and informational assistance from family, friends, and peers. Hence, maternity unit managers should endorse and facilitate doula companionship, as it can positively impact health promotion behaviors by offering encouragement, practical assistance, and a sense of belonging.

Pain relief during labor is a crucial aspect of labor management; it takes the form of non-pharmacological methods in the latent phase and pharmacological interventions in the active phase. The findings indicated that most registered midwives administered pain relief during labor. Another study emphasized that pain often surpasses pregnant women's intrapartum expectations, emphasizing the importance of encouraging women to seek help for pain relief during labor [26]. However, another study concluded that women sometimes did not receive pain relief during labor and that their requests were ignored, even when they expressed pain [27]. HPM emphasizes the importance of the availability and accessibility of pain management options as situational influences that influence the choices and experience of a woman during labor. The situational influence of pain management options can affect a woman's perceived control, comfort, and ability to actively participate in the birthing process. Therefore, both pharmacological interventions and non-pharmacological techniques for pain relief during labor are crucial for enhancing the overall experience of labor and delivery for women.

The intrapartum period demands the highest care for pregnant women. The results revealed that most of the respondents believed that they provided adequate care to women during labor and childbirth. On the contrary, a study indicated that registered midwives often do not meet the professional standards of care that address the basic needs of women during labor and childbirth [26]. Furthermore, some women felt that they did not receive adequate care acceptable to them due to the inaccessibility or lack of services. Another study concluded that appropriate midwifery services depend primarily on the knowledge, experience, and skills of midwives [28].

The second stage of labor is often considered intolerable both for the woman and the fetus. It is defined as the time from complete cervix dilation to the birth of the baby involving expulsive uterine contractions that cause an involuntary urge to push [29]. Less than half of the respondents indicated that they would stay with women when the second stage of labor was imminent, while more than half disagreed with staying during this phase. This disagreement, which affects a significant number of midwives, implies that most registered midwives could not manage to stay with women during the imminent second stage of labor due to the challenges of simultaneously caring for multiple women. In situations where multiple women are in the second stage of labor, registered midwives may need to move between two or more labor rooms to provide adequate care. The study carried out emphasizes the need for continuous support during the second stage of labor and that changes in staff during this period of time should be avoided if possible [30].

HPM underscores commitment to a plan of action, which is crucial to promoting and supporting the health and well-being of women and their babies. Additionally, midwives play a vital role in providing holistic care, education, and guidance throughout the antepartum, intrapartum, and postpartum periods, which is considered appropriate. Lack of appropriate midwifery care can lead to increased maternal and neonatal morbidity and mortality, potentially resulting in legal problems.

Practices among registered midwives differ during the second stage of labor, with individual approaches influenced by their knowledge, skills, and experience. However, it

is emphasized that these practices should ultimately be guided by evidence-based principles [30]. According to the Health Promotion Model (HPM), the inability of registered midwives to stay with women when the second stage of labor is imminent is seen as a situational influence. This means that midwives who manage a large number of women may find it challenging to be present during this critical phase, potentially contributing to elevated rates of maternal and newborn mortality and morbidity, as well as medico-legal issues. The departure of midwives during the imminent second stage of labor hinders the delivery of quality care and contradicts the "Scope of Practice of a Midwife", which mandates their presence until after the birth, depending on the condition of the patient and child. This underscores the urgent need for increased midwife staff in maternity units to ensure adequate care and prevent maternal and newborn mortality and morbidity.

The nursing and midwifery council has issued guidelines for record keeping, including maternity case records, regardless of their format [31]. Findings indicate that documentation in various books, such as Partogram and admission books, is a common practice. Another study highlights the widespread use of the maternity registry as a comprehensive perinatal care document provided by the national health department, although it is acknowledged as repetitive [32]. Midwives express frustration over redundant documentation, which often repeats information. In contrast, another study revealed that midwives tend not to record their actions extensively, limiting the entries to observations when abnormalities arise [33]. This could be attributed to the time restrictions faced by midwives, who manage multiple records while simultaneously providing care to several women in labor. The Health Promotion Model identifies a lack of time as a perceived barrier to actions. Furthermore, the requirement for midwives to use multiple books consumes significant time, thus compromising the quality of care provided to women. Therefore, the Department of Health (DoH) has a pressing need to consolidate information into at least two books, thus reducing redundancy, eliminating repetition, and saving valuable time.

The postpartum period is a demanding time in the life of a woman, with sudden changes in the roles and responsibilities of the woman. Most of the respondents indicated that they gave health education to mothers during the postpartum period. In contrast to this study's findings, another study found a lack of general health education after childbirth [34].

Furthermore, midwives appeared to be reluctant to provide health education to multiparous women. This reluctance could be due to the fact that registered midwives often feel overwhelmed by the large number of patients they encounter, which may limit their ability to provide comprehensive health education [35]. This could be due to the low staff-to-patient ratios that have been reported in other studies in low-income settings [36]. According to HPM, health education for postpartum mothers is crucial to promote their well-being and facilitate a healthy transition to motherhood. Therefore, women should be surrounded by registered midwives who will emotionally support them by providing health education.

The WHO recommends that every newborn baby be fed breast milk within 1 h after birth. Therefore, the initiation of breastfeeding within the first hour of life lays the foundation for optimal breastfeeding. The results revealed that less than half of the respondents indicated support for the mother at the beginning of breastfeeding. The WHO supports early breastfeeding as it has different health benefits, such as increased ability to defend against infections, reduced risk of diarrhea, and increased survival rate for children [6]. In contrast, another study indicated that early initiation of breastfeeding was poorly practiced by mothers who gave birth, especially in developing countries due to the lack of support from registered midwives [36]. According to HPM, delayed breastfeeding initiation could result from insufficient knowledge and support provided by registered midwives. Additionally, the demands of attending to multiple women during labor and childbirth can serve as barriers to prompt action or early initiation of breastfeeding. Maternity unit managers should recommend short courses or in-service training on breastfeeding so registered midwives can be empowered to support the mother to initiate breastfeeding early.

The postpartum period is equally important in the life of a new mother as the antenatal and intrapartum periods. The WHO notes that the postpartum period is one of the most dangerous and still neglected periods in the life of the mother [6]. More than half of the respondents indicated that they addressed complications promptly during the postpartum period. However, around 36.8% of respondents stated that they did not consistently address complications promptly. The results of the study differ from another study that found that due to a lack of adequate knowledge and skills regarding the identification of postpartum complications, such as postpartum hemorrhage (PPH) and puerperal infection, many cases go undiagnosed and mismanaged [37]. According to HPM, lack of prompt management of postpartum complications could be influenced by a lack of knowledge and skills to perform a particular action or treatment of the complication, which can act as a barrier. Registered midwives may feel unsure about how to initiate or carry out the desired action, leading to hesitation or avoidance. Postpartum complications can lead to severe maternal morbidity and mortality. Therefore, maternity care must emphasize continuous service in identifying and managing postpartum complications, to achieve goal three of the SGD.

4.3. Limitations of the Study

The research was carried out in the maternity units of two district hospitals located in the Waterberg district of the Limpopo Province. It is crucial to emphasize that the findings of this study should not be extrapolated to other public hospitals in South Africa. The data gathering process specifically targeted registered midwives working day shifts, making it imperative to avoid generalizing the results to include registered midwives on leave or those working night shifts.

5. Conclusions

In summary, the findings highlight significant gaps in the knowledge and skills of many registered midwives, particularly in specialized maternal and newborn care. Older midwives, despite their experience, struggle with the demands of late-night shifts and the physical strain of labor and delivery. Additionally, deficiencies in midwifery specialization impede the delivery of quality care, thus posing risks to pregnant women and newborns. Insufficient training and experience, coupled with challenges in providing continuous support during labor, underscore the need for additional training and staffing programs. Despite efforts to provide emotional support, inconsistencies persist in midwifery practices, particularly in pain relief management during labor and postpartum education. Challenges in staying with women during labor's critical stages highlight the need for increased staffing levels. To address these issues, this study recommends investment in training programs, improved staffing, promotion of doula companionship, and better documentation practices. Prioritizing these initiatives can improve the quality of midwifery care, reduce maternal and neonatal morbidity and mortality, and contribute to achieving Sustainable Development Goal Three.

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