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Factors influencing the quality of induction of labour at a district hospital in Tshwane: A qualitative study

Mathevula, R. F., & Mosesane-Kuduntwane, G. P.

Department of Nursing Science, School of Healthcare Sciences, Sefako Makgatho Health Sciences University, Molotlegi Street, Ga-Rankuwa, South Africa

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Correspondence to:
Dr. Rirhandzu Friddah Mathevula
rirhandzu.mathevula@smu.ac.za

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ABSTRACT

Introduction

Induction of labour is a widely used obstetric intervention performed when continuation of pregnancy poses risks to maternal or fetal health. In South Africa's public healthcare sector, induction rates remain high. Outcomes are closely linked to the quality of care, which is influenced by clinical practices, health system factors, and resource constraints. Associated risks include failed induction, uterine hyperstimulation, and emergency caesarean delivery.

Purpose

This study aimed to explore factors influencing the quality of induction of labour practices among midwives at a district hospital in Tshwane, South Africa.

Method

A qualitative exploratory descriptive design was employed. The study was conducted at a busy district hospital in the Tshwane District, Gauteng Province. Purposive sampling was used to recruit 16 female midwives qualified in basic and advanced midwifery, aged 27–64 years, each with at least two years of experience and direct involvement in labour induction. Data were collected between July and August 2023 through in-depth semi-structured interviews. Interviews were audio-recorded with participants' consent and transcribed verbatim. Data were analysed using the thematic analysis approach described by Braun and Clarke.

Results

Analysis revealed one overarching theme, *systemic barriers compromising induction quality*, comprising three subthemes derived from participant responses. Five participants reported (1) overbooking and heavy caseloads leading to rushed procedures; seven participants highlighted (2) increasing induction volumes alongside fixed staffing levels; and seven participants identified (3) inadequate institutional support, including limited access to guidelines, insufficient training, and lack of multidisciplinary support. These factors collectively undermine clinical decision-making, adherence to protocols, and overall quality of care, while also contributing to midwife burnout and adverse maternal–fetal outcomes.

Conclusion

The findings highlight systemic challenges at a district hospital in Tshwane that compromise the quality of labour induction. These results underscore the need for urgent interventions, including strengthened institutional support, implementation of a scheduling cap of three inductions per day, staffing reviews, and the establishment of quarterly induction of labour (IOL) review mechanisms.

INTRODUCTION

Induction of labour (IOL) is a common obstetric intervention aimed at initiating uterine contractions before their spontaneous onset to achieve timely delivery when continuation of pregnancy poses risks to the mother or fetus (Fiolna, 2021). Over the past decade, IOL rates have increased significantly worldwide, reflecting evolving clinical guidelines, changing maternal profiles, and expanded indications for the procedure (Michail et al., 2025). Although effective when appropriately indicated, the quality of the induction process is critical. Poorly managed or inappropriate IOL is associated with maternal and neonatal complications, increased intervention rates, prolonged hospital stays, and patient dissatisfaction (Mustafa et al., 2024). The quality of IOL is multifaceted and influenced by adherence to evidence-based protocols, resource availability, interdisciplinary coordination, and the quality of communication and support provided to women (Mokwena & Madiba, 2022; Thorsen et al., 2023).

In South Africa, high maternal and perinatal mortality rates remain a pressing public health concern, with district hospitals serving as critical frontline healthcare facilities. The Tshwane District, a major metropolitan area in Gauteng Province, exemplifies settings where high patient volumes intersect with well-documented constraints in human resources, infrastructure, and equipment. These challenges may compromise the delivery of consistent, high-quality obstetric care (Pattinson et al., 2021). Within this context, IOL practices are particularly vulnerable to systemic challenges; however, there is a paucity of detailed, context-specific analyses on how these challenges manifest and are managed at the point of care.

This study was conducted at a district hospital in Tshwane, selected as a typical case due to its central role as a referral centre for surrounding communities and its representation of the resource dynamics and clinical demands common to public-sector district hospitals in the region. A focused investigation at this site allows for an in-depth understanding of the operational realities influencing this key obstetric intervention.

Existing literature on IOL quality primarily focuses on clinical outcomes, audit data, or patient satisfaction, with fewer studies explicitly exploring the perspectives of frontline providers responsible for implementing the procedure (Smith et al., 2023; Thorsen et al., 2023). This represents a significant knowledge gap, particularly in resource-constrained settings where contextual factors strongly influence care quality (World Health Organization [WHO], 2022). In the South African context, midwives are legislated as the primary healthcare providers responsible for managing normal labour and IOL in district hospitals (South African National Department of Health [NDoH], 2020; Mokwena & Madiba, 2022).

Midwives spend the most prolonged and continuous time with women undergoing induction, positioning them uniquely to observe the facilitators and barriers to quality care. However, a systematic review of the literature indicates that midwives' perspectives on IOL quality remain underexplored in the local context. Therefore, this study aims to explore midwives' perspectives on the quality of induction of labour at a district hospital in Tshwane, with a specific focus on the barriers and facilitators to delivering high-quality care. The findings are expected to generate rich, contextual insights into the operational, professional, and systemic factors influencing IOL quality at the clinical frontline, thereby informing feasible and targeted quality improvement interventions.

METHODS

Study Design

A qualitative exploratory descriptive design was employed. This approach was deemed most appropriate as it facilitates a deep and nuanced understanding of participants' experiences, perceptions, and the meanings they attribute to a phenomenon, aligning with the study objective of exploring midwives' perspectives (Creswell & Poth, 2024). The design enabled detailed exploration of factors influencing the quality of induction of labour from the perspective of frontline practitioners, generating rich contextual insights not readily accessible through quantitative methods (Polit & Beck, 2022).

Study Setting

The study was conducted in the labour ward of a district hospital in the Tshwane Metropolitan Municipality, Gauteng Province. The hospital was purposively selected as a typical case of a high-volume public-sector district facility. It is located approximately 3.2 kilometres from Pretoria Central and serves as a key referral centre for surrounding

communities, managing an estimated 388–400 maternity admissions per month.

The labour ward is a 19-bed unit configured to accommodate antenatal care, isolation, delivery, and first-stage labour. This setting provided a relevant and information-rich context for examining the operational realities of IOL practice within a resource-constrained but essential clinical environment.

Study Population and Sampling

The total population comprised 131 midwives employed at the hospital. The target population included the 36 midwives assigned to the labour ward, who are primarily responsible for managing IOL from initiation to delivery.

Purposive sampling was used to select participants from this group. This non-probability sampling technique enabled the identification of information-rich participants with direct and substantial experience in IOL, allowing for in-depth exploration of the phenomenon under study (Campbell et al., 2020).

The final sample consisted of 16 midwives who met the inclusion criteria:

a) registration with the South African Nursing Council as a midwife;
b) a minimum of two years' professional experience; and
c) current employment in the labour ward with direct responsibility for managing IOL.

The sample size was determined by data saturation, defined as the point at which no new themes or insights emerged from the data (Busetto et al., 2021).

Table 1:
Study Population and Sample

Population Category	Description	Number
Total population	All midwives employed at the hospital	131
Target population	Midwives working in the labour ward	36
Accessible population	Midwives meeting inclusion criteria	16
Final sample	Participants selected through purposive sampling	16

Data Collection

Data were collected through individual, semi-structured, face-to-face interviews conducted in English, which all participants were proficient in professionally. An interview guide was developed and piloted with three midwives (excluded from the main study) to refine question clarity and flow. This ensured consistency while allowing flexibility to explore emerging ideas.

Key questions focused on midwives' experiences, perceived barriers, facilitators, and contextual challenges related to delivering quality IOL care. Interviews were scheduled at participants' convenience, primarily during work breaks, to minimise disruption to clinical duties. Each interview lasted between 25 and 40 minutes, was audio-recorded with participants' consent, and supplemented with brief field notes capturing non-verbal cues and contextual observations.

All recordings were transcribed verbatim by the researcher, and transcripts were cross-checked against the audio recordings to ensure accuracy prior to analysis.

Trustworthiness

The rigor of the study was ensured using strategies aligned with established qualitative criteria for trustworthiness (Lincoln & Guba, 1985).

Credibility was achieved through member checking, whereby a summary of preliminary themes and illustrative quotes was shared electronically with all 16 participants. Participants confirmed that the findings accurately reflected their experiences. Prolonged engagement during data collection further enhanced credibility.

Dependability was ensured by maintaining a comprehensive audit trail, including raw data, transcripts, field notes, and detailed documentation of analytic decisions. The stepwise thematic analysis process, combined with the involvement of an independent coder, ensured a transparent and logical research process.

Confirmability was established through the use of audio-recorded interviews, field notes, independent coding, and supervisory oversight. The inclusion of an independent coder, ongoing supervisory discussions, and the maintenance of a reflexive journal helped minimise researcher bias and ensured that findings were grounded in the data.

Transferability was supported through detailed descriptions of the study context, participant characteristics, and

research processes, as well as by referencing relevant literature and acknowledging study limitations. Sample size determination based on data saturation further strengthened the applicability of the findings (Renjith et al., 2021).

Ethical Approval

Ethical approval was obtained from the Sefako Makgatho Health Sciences University Research Ethics Committee (SMUREC/H/337/2023:PG) and the National Health Research Database (GP-202310-028).

The study adhered to established ethical principles for health research (Gray & Grove, 2020). Written informed consent was obtained from all participants prior to data collection. Participants were fully informed about the purpose, procedures, potential risks, and benefits of the study.

Confidentiality and privacy were strictly maintained through secure data storage, restricted access to identifiable information, and anonymised reporting of findings. Participation was voluntary, and participants were informed of their right to withdraw from the study at any stage without penalty. These measures ensured the protection of participants' rights, dignity, and well-being throughout the research process.

Data Analysis

Data were analysed using the six-phase framework for reflexive thematic analysis. The process was iterative and included the following phases:

1) familiarisation with the data through repeated reading of transcripts and review of audio recordings;
2) systematic generation of initial codes across the dataset;
3) development of preliminary themes by grouping related codes;
4) review and refinement of themes to ensure coherence and alignment with the dataset;
5) defining and naming themes to clearly capture their conceptual meaning; and
6) production of the final analytical narrative, in which themes were synthesised and contextualised within relevant literature.

This structured and transparent approach ensured a rigorous and credible qualitative analysis.

RESULTS

Demographic Characteristics of Participants

Sixteen female midwives working in the labour ward of a district hospital in Tshwane participated in the study. Participants ranged in age from 27 to 64 years. Their professional experience varied from 2 to 18 years, and they held diverse nursing qualifications, including diplomas, bachelor's degrees, and postgraduate diplomas in midwifery and neonatal nursing. This range of experience and qualifications provided diverse professional perspectives on factors influencing the quality of induction of labour (IOL). A summary of participant characteristics is presented in **Table 2**.

Table 2:
Demographic Characteristics of Participants

Participant	Age	Category	Highest Qualification	Years of Experience
1	64	Advanced midwife	Bachelor's degree in nursing	17
2	30	Midwife	Bachelor's degree in nursing	7
3	42	Midwife	Diploma in nursing	4
4	45	Advanced midwife	Postgraduate diploma in midwifery and neonatal nursing	7
5	27	Midwife	Bachelor's degree in nursing	3
6	30	Midwife	Diploma in nursing	5
7	42	Advanced midwife	Postgraduate diploma in midwifery and neonatal nursing	18
8	34	Midwife	Bachelor's degree in nursing	5
9	31	Midwife	Diploma in nursing	3
10	28	Midwife	Diploma in nursing	4
11	32	Midwife	Diploma in nursing	2
12	33	Midwife	Diploma in nursing	8
13	30	Advanced midwife	Postgraduate diploma in midwifery and neonatal nursing	5
14	28	Midwife	Bachelor's degree in nursing	2
15	30	Midwife	Bachelor's degree in nursing	5
16	51	Midwife	Diploma in nursing	10

Main Findings

Thematic analysis identified one overarching theme and three interrelated subthemes related to factors influencing the quality of IOL from the midwives' perspective. These are presented in **Table 3**.

Table 3:
Theme and Subthemes

Main Theme	Subthemes
Systemic and workload-related factors influencing quality of IOL	1. Overbooking of mothers for IOL
	2. Increased number of inductions compromising quality of care
	3. Limited support systems for midwives

Theme 1: *Systemic and Workload-Related Factors Influencing Quality of IOL*

This overarching theme captures institutional and operational challenges shaping IOL care. Participants consistently described a work environment where structural factors—particularly excessive patient loads, high induction rates, and insufficient support—undermined their ability to provide safe, attentive, and guideline-adherent care.

Subtheme 1: *Overbooking of Mothers for IOL*

Five participants reported that routine overbooking of IOL cases exceeded the hospital's recommended daily limit. This practice, combined with unfavourable midwife-to-patient ratios, compromised monitoring, increased clinical risk, and contributed to professional dissatisfaction.

Illustrative quotes:

- *P4:* "When doctors see many women needing induction, they exceed the standard number of three without considering staffing levels, which affects the quality of care."
- *P3:* "Doctors do not consider how many midwives are on duty; they book as many women as possible."
- *P2:* "When a woman is in labour, she needs close monitoring. That is why we should not induce more than three women at a time."
- *P6:* "We are often only four or five midwives on duty, yet we manage more than the recommended number of inductions."
- *P8:* "Induction requires careful monitoring because of risks like hyperstimulation and fetal distress."

Subtheme 2: *Increased Number of Inductions Compromising Quality of Care*

Seven participants reported that increasing IOL volumes, driven by late antenatal care (ANC) attendance, fear of diagnosis, negative healthcare experiences, and long waiting times, contributed to excessive workloads and reduced quality of care.

Illustrative quotes:

- *P9:* "We are short-staffed, and the number of inductions does not match the available midwives."
- *P1:* "Many women delay ANC due to lack of knowledge or fear of exposing their pregnancy."
- *P7:* "Late bookings and undiagnosed cases increase emergency inductions."
- *P12:* "Long waiting times discourage early ANC attendance."
- *P10:* "The IOL list is too long, so doctors exceed the recommended number."
- *P4:* "Some women avoid induction due to previous negative experiences."
- *P13:* "High IOL numbers compromise the quality of care, especially when emergencies occur."

Subtheme 3: *Limited Support Systems for Midwives*

Seven participants highlighted inadequate institutional and professional support as a major barrier to quality IOL care. Key concerns included limited training opportunities and insufficient medical support after hours.

Illustrative quotes:

- *P11:* "Doctors are only available during the day; after hours, we rely on casualty or referral hospitals."
- *P16:* "After hours, we consult doctors unfamiliar with labour ward procedures."
- *P14:* "We serve many communities but lack sufficient management support."
- *P15:* "Patient numbers are increasing, but staffing remains limited."
- *P6:* "I have never received formal training on IOL."
- *P8:* "There is no ongoing in-service training."
- *P5:* "Since I started working here, I have not attended any IOL training."

DISCUSSION

This discussion interprets the findings in relation to existing literature, focusing on the three identified subthemes that collectively highlight systemic challenges affecting the quality of IOL care.

Overbooking of Mothers for IOL

Participants reported that the recommended daily limit for IOL is frequently exceeded, reflecting a broader tension between clinical guidelines and the realities of resource-constrained settings. This finding aligns with existing evidence that healthcare systems under pressure often prioritise service demand over safe staffing ratios (Malatji & Madiba, 2020).

Overbooking compromised midwives' ability to provide adequate monitoring, particularly for complications such as uterine hyperstimulation and fetal distress. This is consistent with findings that increased patient loads negatively affect care quality and patient safety in maternity settings (Afghani et al., 2024). Effective IOL protocols depend on adequate staffing and resources (Hamm et al., 2025), and deviation from these standards reflects systemic, rather than individual, shortcomings.
However, these findings are context-specific and may not be generalisable to rural or well-resourced settings.

Increased Numbers of Inductions Compromising Quality of Care

Participants linked high IOL volumes to gaps in antenatal care, including late bookings, fear of diagnosis, and negative healthcare experiences. This reflects a cyclical pattern in which poor ANC uptake leads to higher-risk pregnancies requiring urgent intervention, thereby increasing pressure on labour wards.

These findings are supported by Bashir et al. (2023), who identified maternal knowledge and prior experiences as key determinants of ANC utilisation. High workloads were also associated with decision-making fatigue, potentially affecting clinical judgement (Souri Nejad et al., 2025).

The current care model contrasts with evidence-based approaches such as caseload midwifery, which emphasise continuity of care and manageable workloads to improve outcomes (Allen et al., 2019). In this study, the system appeared to prioritise service volume over woman-centred care.

Limited Support Systems for Midwives

Participants identified gaps in training and access to senior clinical support as critical barriers to quality care. The absence of structured IOL training undermined confidence and adherence to protocols, consistent with findings by Amod et al. (2024), who linked inadequate training to reduced clinical competence.

Limited after-hours medical support further increased clinical risk, as midwives were required to manage complex cases with minimal guidance. Supportive leadership and accessible supervision are essential for effective guideline implementation (Okeke & Ngunyulu, 2025), yet were perceived as lacking in this setting.

Additionally, participants described an organisational culture that placed responsibility for professional development on individuals, which contradicts principles of supportive clinical governance and continuous professional development.

Implications of the Findings

The findings indicate that systemic pressures—particularly overbooking, high workloads, and limited support—create conditions in which high-quality IOL care is difficult to achieve. These challenges contribute to delayed interventions, reduced individualised care, and increased risks of adverse maternal and neonatal outcomes.

Addressing these issues requires system-level interventions, including:

- Enforcing IOL booking limits aligned with staffing capacity
- Strengthening antenatal care systems to reduce late presentations
- Implementing structured and mandatory IOL training programmes
- Ensuring consistent access to senior clinical support

Improving IOL quality therefore necessitates addressing broader structural and organisational factors rather than focusing solely on individual clinical performance.

Limitations

This study has several limitations. First, the use of purposive sampling at a single urban district hospital limits

the generalisability of the findings. Second, the potential for social desirability bias exists, despite assurances of anonymity. Third, researcher positionality may have influenced data collection and interpretation, although reflexive strategies were employed to mitigate bias.

Additionally, data were collected at a single point in time, and organisational conditions may have since changed. Finally, as a qualitative study, the findings describe perceptions and associations rather than causal relationships. Further quantitative and multi-site research is recommended to validate and expand upon these findings.

CONCLUSION

This study highlights the urgent need to address overbooking and workload pressures in district-level induction of labour (IOL) services. Key strategies include implementing structured scheduling systems, increasing staffing capacity, providing ongoing midwifery training, strengthening interprofessional collaboration, improving communication, and conducting routine quality audits to enhance care delivery.

These interventions have the potential to improve maternal and neonatal outcomes, support national health priorities, and inform scalable solutions for under-resourced healthcare settings. Future research should examine the long-term impact of these interventions and explore the integration of technology to optimise IOL management and service delivery.

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Ethical Approval: Ethical approval was obtained from the Sefako Makgatho Health Sciences University Research Ethics Committee (SMUREC/H/337/2023:PG) and the National Health Research Database (GP-202310-028).

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ORCID iDs:
Mathevula, R. F.: https://orcid.org/0000-0002-2534-6302
Mosesane-Kuduntwane, G. P.: https://orcid.org/0009-0005-0183-0019

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