COMMUNICATION EXPERIENCES OF EXPATRIATE MIDWIVES PROVIDING MATERNITY CARE IN A MILITARY HOSPITAL IN SAUDI ARABIA

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DECLARATION

By submitting this thesis electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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ABSTRACT

Background

In Saudi Arabia, maternity care is provided by expatriate midwives. The official language of Saudi Arabia is Arabic. The labour ward communication amongst expatriate midwives and Saudi patients was unique as the first language of expatriate midwives is not Arabic. The limited research focuses on the expatriate nurses' communication experiences in Saudi Arabia. The aim of the study was to explore and describe the communication and the communication experiences of expatriate midwives while caring for pregnant woman in the labour and delivery ward of a military hospital in Saudi Arabia.

Methods

A qualitative descriptive methodology was used to explore the views of expatriate midwives regarding effective communication with patients in the labour and delivery ward. The study applied purposive sampling to select participants from the labour and delivery ward of a military hospital in Saudi Arabia. The Health Research and Ethics Committee of Stellenbosch University and the Research and Ethics Department of the hospital granted permission to conduct the study. Seven semi-structured interviews were conducted, transcribed and analysed using Creswell's framework. Four themes emerged from the data.

Results

The themes that emerged were: communication methods, communication challenges, communication rationale and communication solutions. Participants expressed their unique communication styles, even though they were not fluent speaking the Arabic language. They stressed the importance of communication in a maternity setting as they provide care for the Saudi nationals and their unborn babies.

Conclusion

Communication is an integral component of providing quality maternity care in the labour and delivery ward. With the assistance of higher management of the hospital, support systems can be in place to bridge the communication gaps between expatriate midwives and the pregnant woman.

Key words: Communication, expatriate nurses, midwife, language

OPSOMMING

Agtergrond

In Saoedi-Arabië word kraamverpleging deur geëkspatrieerde vroedvroue verskaf. Die amptelike taal van Saoedi-Arabië is Arabies. Die kraamsaal-kommunikasie tussen geëkspatrieerde vroedvroue en Saoedi-pasiënte was uniek omdat die geëkspatrieerde vroedvroue se eerste taal nie Arabies was nie. Beperkte navorsing het gefokus op die geëkspatrieerde vroedvroue se siening oor kommunikasie in Saoedi-Arabië. Die doel van die studie was om die rol van kommunikasie en kommunikasie ervarings tussen pasiënte en geëkspatrieerde vroedvroue wat in die kraamafdeling van 'n militêre hospitaal in Saoedi-Arabië gewerk het, te ondersoek en te beskryf.

Metode

vroedvroue te ondersoek rakende effektiewe kommunikasie met pasiënte in die kraamafdeling. Die studie het doelgerigte steekproefneming toegepas om deelnemers uit die kraamafdeling van 'n militêre hospitaal in Saoedi-Arabië te kies. Die Gesondheidsnavorsings- en Etiekkomitee van die Universiteit Stellenbosch en die Navorsings- en Etieksentrum van die hospitaal het toestemming verleen om die studie te doen. Sewe semi-gestruktureerde onderhoude is uitgevoer, getranskribeer en geanaliseer met behulp van Creswell se raamwerk. Vier temas het uit die data ontstaan.

Resultate

Die temas wat na vore gekom het, was: kommunikasiemetodes, kommunikasie-uitdagings, kommunikasie-rasionale en kommunikasie-oplossings. Deelnemers het hul unieke kommunikasiestyle bespreek, alhoewel hulle nie die Arabiese taal vlot kon praat nie. Hulle beklemtoon die belangrikheid van kommunikasie in 'n kraamomgewing, aangesien hulle nie alleen vir die Saoedi-vroue sorg nie, maar ook vir hul ongebore babas.

Slotsom

Kommunikasie is 'n integrale komponent in die voorsiening van gehalte kraamsorg. Met die hulp van die hospitaal se topbestuur kan ondersteuningstelsels in plek gestel word om die kommunikasie-uitdagings tussen geëkspatrieerde vroedvroue en die Saoedi-pasiënte te oorbrug.

Sleutelwoorde: Kommunikasie, geëkspatrieerde vroedvroue, taal

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ABBREVIATIONS

KSA	Kingdom of Saudi Arabia
VE	Vaginal examination
MOH	Ministry of Health
MCH	Maternity and Child Health Clinic

CHAPTER 1: FOUNDATION FOR THE STUDY

1.1 Introduction

Birth is a dynamic and transforming experience for a family and the community. Expecting a new baby is life-changing and the pregnant woman needs a supportive environment and to be empowered for her journey ahead (Marshall & Raynor, 2014:328). Pregnancy is a physiological process whereby all pregnant women await the birth of their baby. It is a "human right" to complete their pregnancy in a healthy way (Turk, Sakar & Erkaya, 2017:1248). Midwives work closely with the pregnant women in the labour and delivery ward with the goal of having a positive birth outcome and increased patient satisfaction (Moawed, Yakhout & Zakary, 2012:406). Communication plays a vital role in enhancing the goal of having a positive birth experience and patient satisfaction, as maternity care is an interactive process between midwives and the pregnant women.

Miscommunication is one of the factors that can jeopardise pregnant women's birth experience, which may lead to patient dissatisfaction with her maternity experience or even life-threatening maternal/new born incidents, which requires appropriate communication between the pregnant women and the midwife (Higginbottom, Safipour, Yohani, O'Brien, Mumtaz & Paton, 2014:298).

The maternity care in Saudi Arabia is challenging due to communication between the pregnant women and the midwife. Midwives in Saudi Arabia are predominantly expatriates recruited by the Ministry of Health in Saudi Arabia, who are from India, Philippines, Malaysia, South Africa, Australia and the United Kingdom (Almutairi & McCarthy, 2012:71). These recruited midwives speak little to no Arabic, which is the official language of Saudi Arabia.

The language of the pregnant women in the labour and delivery ward is limited to Arabic with very little English known. The employer expects all the midwives to speak fluent English. With the pregnant women speaking Arabic, and the expatriate midwives speaking English, a communication challenge is evident. The communication challenge begins with the pregnant women who present to the labour and delivery ward as she requires midwifery care for herself and the unborn baby. The pregnant women arrive at the labour and delivery ward during different stages of labour (Marshall & Raynor, 2014:328) and the midwifery interventions depend on these stages of labour. The more advanced the labour stage is, the more limited the time is to know their reasons for coming to the hospital, their obstetric history, or their main complaint and symptoms as the labouring women's focus is on resolving her labour pain.

The communication interaction and experiences of the expatriate midwives caring for the pregnant women is based on broken Arabic, non-verbal communication which included body gestures. (Armstrong, Bhengu, Mthembu, Ricks, Stellenberg, Van Rooyen, Vasuthevan & Geyer, 2013:268). The interaction with the pregnant women is further complicated by their religious and cultural practices.

The expatriate midwife's journey with a Saudi pregnant woman is, therefore, influenced by factors such as communication, religion and cultural differences. These factors might influence the expatriate midwives' contribution to a positive birth experience of the pregnant woman and her baby. To optimise the expatriate midwives' contribution, the question is asked "What are the communication experiences of the expatriate midwives with the pregnant woman in a labour and delivery ward in Saudi Arabia?"

1.2 Significance of the problem

The labour and delivery ward in the hospital where the researcher works as a clinical instructor, provides maternity services to pregnant women and is one of the 268 hospitals situated in the Kingdom of Saudi Arabia (MOH, 2013:27).

The labour and delivery ward is a critical area for communication as midwives provide care and close monitoring to all pregnant women. Ineffective communication in midwifery could lead to miscommunication between patients and providers, an incorrect diagnosis and inappropriate treatment, which could, in turn, lead to adverse birth outcomes (Clough, Lee & Chae, 2013:389).

Effective communication between the pregnant women and the expatriate midwives enhances the women's birth outcomes and provides a higher satisfaction in maternity management. Expatriate midwives also need to offer the pregnant women continuous support in labour by providing companionship, attending to her physical and emotional needs and providing information and advice (Moawed et al. 2012:4015). It is therefore accepted that the midwives provide intense management to care for the pregnant women. The communication experiences impact these services to the pregnant women, as the expatriate midwives speak little to no Arabic.

The Saudi Arabian nationals have a strongly-rooted culture. They follow the Islamic faith and adhere to its religious practices. This can impact their care especially during the Holy month of Ramadan where they fast from sunrise to sunset. Pregnant women would abstain from ingesting any food or drink during this period, which may affect the health of the pregnant mother and the unborn baby.

Due to the difficulty of communication between the expatriate midwives and the pregnant women, it was found necessary and important to explore this problem as communication plays a vital role in providing care to these pregnant women.

1.3 Rationale

The researcher found effective communication to be a vital element to prevent mismanagement, miscommunication and provide safe maternal and newborn care. Therefore, the researcher wanted to explore the expatriate midwives' means of communication while providing maternity care to the pregnant women.

The researcher observed that when the pregnant women were admitted, only their eyes were visible until they removed their abaya, burka and hijab (female clothing worn by Saudi women to cover their body and face). The presence of the pieces of clothing limited communication as their facial expressions could not be seen. When the clothing was removed, they appeared either sad, crying due to their pain, or holding their abdomen as a sign of experiencing labour pain. These gestures would alert the expatriate midwives that the pregnant women were in pain.

The researcher also noted that the expatriate midwives had their own unique way of communicating with pregnant women. Maternity care included close monitoring of the pregnant women, which required verbal and non-verbal communication. In Saudi Arabia, the use of touch, limiting personal space, eye contact and intimacy is considered unwelcome (Albougami, 2015:167). It became of interest to explore the role of culture and experiences of communication within healthcare, in an effort to provide holistic care for pregnant women (Albougami, 2015:167).

1.4 Research problem

Expatriate midwives provide care and management to all pregnant women in the labour and delivery ward of a military hospital in Saudi Arabia. Communication in the labour and delivery ward is necessary to achieve the goal of a healthy mother and healthy baby. The expatriate midwives could not speak Arabic with the pregnant women. The reality is that the expatriate midwives came from different countries and they seem to communicate uniquely with the pregnant women to provide effective maternity care.

The expatriate midwives were concerned as communication could lead to information being miscommunicated and their symptoms could be mismanaged. The communication experiences of expatriate midwives needed exploring to prevent miscommunication, mismanagement and a negative birth experience for the pregnant women. By doing this study,

the expatriate midwives could verbalise their communication challenges and possibly find solutions to bridge the communication gap. If the communication experiences of the expatriate midwives were not explored, potential communication challenges could persist, thus resulting in a potential negative birth experience for the pregnant women and mismanaged care to both the pregnant mother and the unborn baby.

1.5 Research question

What are the communication experiences of the expatriate midwives while caring for the pregnant women in the labour and delivery ward of a military hospital in Saudi Arabia?

1.6 Research aim

The aim was to explore and describe the communication experiences of expatriate midwives while caring for pregnant women in the labour and delivery ward of a military hospital in Saudi Arabia.

1.7 Research objectives

The research objectives were to:

- Describe communication of expatriate midwives while caring for the pregnant women in the labour and delivery ward of a military hospital in Saudi Arabia
- Explore the communication experiences of the expatriate midwives while caring for pregnant women in the labour and delivery ward of a military hospital in Saudi Arabia

1.8 Research methodology

The research methodology used will be discussed briefly in this chapter, with a more detailed discussion following in Chapter Three.

1.8.1 Research design

In this study, the researcher followed a descriptive qualitative design. The purpose was to provide a picture of situations as they naturally happened (Grove, Burns & Gray, 2013:215). The researcher explored communication by the expatriate midwives in the labour and delivery ward and their experiences during these communication exchanges. By doing a qualitative descriptive study, expatriate midwives were interviewed so that they could verbalise how communication affects them in their workplace.

1.8.2 Study setting

The study was conducted in the labour and delivery ward of a 222-bedded military hospital situated in Saudi Arabia. People from different countries, including South Africa, Malaysia, United States, United Kingdom, Canada, Philippines and India are employed as midwives. The ward averages approximately 200 deliveries per month. .

The official languages spoken at the hospital were Arabic and English. Expatriate midwives were not fluent in speaking Arabic and for some of the expatriate midwives, English was not their first language either. The pregnant women spoke fluent Arabic, as English was not their first language. The pregnant women would, therefore, be exposed to English and broken Arabic in the labour and delivery ward.

The midwifery training for Saudi nationals was implemented in January 2015 and completed in December 2016 in the study setting. This would essentially improve communication in the labour and delivery ward and help to promote further Saudi students to be trained in midwifery. As there were no Saudi midwives employed in the labour and delivery ward at the time during data collection, maternity care was wholly dependent on expatriate midwives.

1.8.3 Population and sampling

Purposive sampling was done by the researcher. In purposive sampling, qualitative researchers select information-rich cases that can provide a lot of information regarding the purpose of the study (Grove, Burns & Gray, 2013:365). Here, the researcher purposively sampled the expatriate midwives that could provide as much information as possible, regarding their views on communication in the labour and delivery ward. There were a total of 15 expatriate midwives who worked in the labour and delivery ward of the hospital and who worked both day and night shifts. A verbal explanation of the study was given to all 15 expatriate midwives.

The pilot interviewee was chosen as she was the first participant that volunteered to participate in the study. The pilot interview was included in the study as the criteria for including the pilot data was reconsidered. The interviewees were asked in private to place their names and contact numbers in a ‘post-box’, that was placed in the labour and delivery ward if they wanted to participate in the study. The box was available in the ward for a week, which allowed time for the midwives to make a voluntary decision. Seven participants placed their names in the box, determining the sample size. The response rate was, therefore, 46.67%, which is a very high margin considering there were only 15 expatriate midwives available in the ward at the time of data collection. The seven names placed in the box were interviewed by an independent field worker.

1.8.4 Data collection tool

A trained, independent field worker conducted individual interviews with the participants. The field worker was a clinical instructor at another military hospital in Saudi Arabia. The independent field worker was used due to ethical reasons as the researcher worked at the study setting. Face-to-face interviews were carried out by the independent field worker with

the participant. A researcher-developed interview guide was used to elicit the communication views experienced by the expatriate midwives in the form of a semi-structured interview. Interviewing skills included probing, clarification, repetition and listening skills.

1.8.5 Pilot interview

A pilot interview was done by the independent field worker with a participant who met the inclusion criteria to refine the interviewer's interviewing skills. This was included in the data collection of the study as it was found to be of adequate quality. The interview was carried out by the independent field worker and reviewed by the study supervisor and co-supervisor.

1.8.6 Trustworthiness

Lincoln and Guba (1985) suggested four criteria for trustworthiness of a qualitative inquiry: credibility, dependability, confirmability and transferability (Polit & Beck, 2012:584). These four criteria provided the initial platform upon which much of the current controversy on rigour emerges (Polit & Beck, 2012:584) that will be explained below.

1.8.6.1 Credibility

Credibility refers to the confidence in the truth of the data and interpretations of it (Polit & Beck, 2012:585). The researcher, study supervisor and co-supervisor strove to establish confidence in the truth of the findings for the particular participants and contexts in the research. Audio-recorded interviews and transcripts were sent to the supervisor to be analysed to enhance the truth of the data. The researcher analysed the data through a process of reflecting, sifting, exploring and judging the transcripts and audio-recorded interviews. One interview was co-coded with the study supervisor and the remaining coding for all the participants were checked by the study supervisor. Themes were developed that accurately depicted the midwives' communication experiences in the labour and delivery ward.

1.8.6.2 Dependability

According to Polit & Beck (2012:585), dependability refers to the stability (reliability) of data over time and conditions. The researcher ensured that all steps undertaken and conditions throughout the study were well-documented to allow for dependability of the study. All interviews followed the same interview guide and were conducted by the same interviewer. Audio-recorded interviews and transcripts were checked and verified by the study supervisor and researcher. An audit trail of communication between the researcher and study supervisor was kept as proof of communication, for example, electronic mail.

1.8.6.3 Confirmability

Confirmability refers to the objectivity or the potential for congruence between two or more independent people about the data's accuracy, relevance, or meaning (Polit & Beck, 2012:585). The researcher made sure that the data provided by the participants was accurate by recording the data during the interview process. Transcripts were verified by the researcher and study supervisor. The researcher also kept an audit trail of how themes and sub-themes were decided upon. Member checking was also done to verify the accuracy of the participants' data and this ensured that the main established themes remained consistent with what they believed as expatriate nurses' views of their engagement with pregnant women in the labour and delivery ward.

1.8.6.4 Transferability

Transferability refers to the potential for extrapolation; that is, extent to which findings could be transferred to or has applicability in other settings or groups (Polit & Beck, 2012:585). The researcher ensured that the context of the study was described richly and intensively in the research documentation. The researcher also provided the same study setting for all participants so that the differences within the study setting could also be controlled for. The findings were discussed in the light of the literature to determine whether the findings resonated with other studies within a global context as well as in Saudi Arabia.

1.8.7 Data collection

After recruitment of participants, the list of participants, including contact numbers, were given to the independent field worker. The field worker then contacted the participants to arrange a date and a time for the interview.

Participants were interviewed on outside of their working hours at their place of residence, which was outside of the hospital premises, so that they felt comfortable. The field worker travelled to the participant's place of residence at their convenience. A transport allowance for the field worker was provided by the researcher. The interview guide was used (Appendix 4) in face-to-face interviews, conducted in English, and which lasted approximately 30-45 minutes.

The interview was recorded by means of a digital recorder, with prior consent from the participants. The files were electronic and the data on the computer was protected by a password. Only the researcher had access to the password. The timeframe for the data collection was 3-4 months (September 2016 – November 2016).

1.8.8 Data analysis

Creswell's six-step analysis was used to analyse the data (Creswell, 2014:247-250). The first step in qualitative data analysis was to organise and prepare the data for analysis. The audio recordings and transcriptions and field notes were organised systematically to prepare the researcher for analysing the data.

The second step was to look at all the data. All the data was read and re-read. Audio recordings of the interviews were transcribed verbatim by the researcher in the researcher's office after each interview. The researcher also received notes from the independent field worker that included body language, gestures and emotions. To ensure the accuracy of the data, critical listening of the audio recordings was done while doing the cross-check of the verbatim transcribed notes.

Step three was to start coding all the data. Similar words, phrases or the actual spoken words by the participants were coded. Different colour highlighter markers were used for the coding. The same colour was used to highlight similar words.

The fourth step after the coding was to identify themes from the coding. The researcher grouped similar codes emerging from the data into themes. A tabular format was used so that the codes and themes could be visualised.

The fifth step was to present the data within a research report. The researcher reported the findings of the data in a research report.

The last step was to interpret the larger meaning of the data. The results were then interpreted by the researcher and the supervisor to generate the findings of this study.

1.9 Ethical considerations

The researcher obtained ethical approval from the Health Research Ethics Committee for Human Science and Research of the Faculty of Health Sciences of Stellenbosch University (Reference number: S16/05/086) (Appendix 1), in July 2016. Ethical approval was also obtained from the Ethical and Research Department of the hospital where the researcher is employed, in September 2016 (Appendix 2).

All participants of the research study were provided with information about the research project and gave written consent for participation in the study (Appendix 3).

The study was conducted according to the ethical guidelines and principles of the Declaration of Helsinki International Guidelines for Good Clinical Practice and the Medical Research Council's Ethical Guidelines for Research.

The guiding ethical principles were the right to self-determination, the right to autonomy, privacy and confidentiality, the right to fair treatment and the right to protection from discomfort and harm (Grove, Burns & Gray, 2013:162), which will be explained individually below.

1.9.1 Right to self-determination

The right to self-determination is based on the principle of respect for persons. An individual has a right to decide how they want to conduct their lives freely without external control (Grove et al. 2013:164). All participants were professional midwives who were capable of making their own decisions. The researcher provided information about the research project by providing an informed consent form. Participants were asked to volunteer to participate in the study. They were not coerced into the study and they were informed that they could withdraw from the study at any time with no penalties.

1.9.2 Right to confidentiality and anonymity

All participants had the right to privacy, anonymity and confidentiality (Grove et al. 2013:171-172). Participants had the right to assume that data collected in the study will be kept confidential. Interviews were carried out in a private room chosen by the participants to ensure privacy. Due to the researcher working at the study site, an independent field worker was trained to conduct the interviews.

The interviews were audio-recorded, which ensured confidentiality. The anonymity of participants was maintained as no names were used, they were given a number and were identified by the specific number, like Participant 1, etc.

Participants were informed prior to providing consent that interviews and data obtained in the study will be shared with the study supervisor. All participants volunteered to participate in the study by placing their names in a sealed envelope, which was kept in the labour and delivery ward.

An informed consent form (Appendix 3) was signed by the participants prior to participating in the study. Interviews were conducted with each participant privately, which gave them the opportunity to withdraw from the study at any time, without being judged by their fellow peers. Participants received no monetary benefits.

1.9.3 Right to protection from discomfort and harm

Based on the principle of beneficence, which states one should do good, but equally do no harm (Grove et al. 2013:174). There were minimal risks, with regards to participating in this study. The possible risks identified included anxiety or embarrassment from answering certain questions. The researcher did not conduct the interviews, which further protected the

participants from discomfort and the fear of being punished by the management of the hospital through anonymity. They were advised that they could exit from the study at any time.

The participants were interviewed during their off-duty time at their accommodation. The time of the interviews were arranged at the discretion of the participants so that they felt comfortable. The researcher was dressed in casual attire and not the hospital attire to avoid participants feeling intimidated. The study used a face-to-face interview, maintaining privacy and confidentiality, so that the participants were protected.

1.9.4 Confidentiality

Stemming from the right to privacy, all participants had a right to ensure all data is kept confidential and it was the researcher's responsibility to ensure that the participants' information was not shared by others without the authorisation of the participant (Grove et al. 2013:172). All data, including the transcripts and the consent forms, were kept in a sealed envelope, in a locked cupboard in the researcher's office, thus making it inaccessible to unauthorised persons. The key for the cupboard was kept by the researcher.

The raw data which was the field notes from the interviews will be kept for a period of five years; after which it will be disposed of by the use of a shredding machine located in the above-mentioned office. The audio recordings collected digitally were saved on the computer and were protected by means of a password and only the researcher had access to this password. The content will be deleted after five years.

Adding to the concept of confidentiality, the field worker that interviewed the participants worked in another hospital, and this maintained the privacy of the participants as she did not know the participants.

1.9.5 The right to fair treatment

The right to fair treatment is based on the ethical principle of justice where individuals must be treated fairly and be given what they are due or owed (Grove et al. 2013:173).

Purposive sampling of participants was done, so there was minimal bias. All the expatriate midwives working in the labour and delivery ward were given a fair chance to participate in the study. The researcher did not conduct the interviews, as she worked at the study setting, and this also prevented bias as the participants did not feel threatened to answer questions for fear of losing their jobs.

All participants were treated fairly, using the same interview guide, and interviewed by the same field worker. Participants were free to withdraw from the study at any time. There were no financial benefits if the participants chose to participate in the study.

1.10 Operational definitions

Communication experiences: Feelings, opinions or views regarding the communication process of the expatriate midwives while caring for the pregnant women in the labour and delivery ward

Communication: Communication experiences of the expatriate midwives while caring for the pregnant women in a labour and delivery ward

Expatriate nurses: Registered midwives who are voluntarily absent from their country of origin and work in Saudi Arabia

Language: A component of communication by expressing signs, words or gestures to convey a message

Midwife: A person who has successfully completed a midwifery education programme in their country of origin and is specifically employed to work as a midwife in a labour and delivery ward of Saudi Arabia (International Confederation of Midwives, 2015)

Pregnant women: Women who are pregnant receiving care in Saudi Arabia

Maternity care: Obstetric care provided to the pregnant woman and the unborn baby

Labour and delivery ward: Specialised ward that admits all pregnant women with a viable fetus

1.11 Duration of the study

The field worker collected data from September 2016 – November 2016. Data analysis commenced from December 2016 – February 2017. The report was written during February 2017 – October 2017 with continuous review by the supervisor. The thesis was submitted in November 2017 for examination.

1.12 Chapter outline

Chapter 1: Foundation of the study

In Chapter One the background and motivation for the research study was described. A brief overview of the literature, research question, research objectives, research methodology, a definition of terms and the layout of the research study were provided.

Chapter 2: Literature review

In Chapter Two the literature relevant to the different communication views experienced by different people worldwide are reviewed and discussed.

Chapter 3: Research methodology

Chapter Three provides an in-depth description of the research methodology used to explore the communication views of expatriate midwives in a labour and delivery ward of Saudi Arabia.

Chapter 4: Results

In Chapter Four the results of the research study are described and interpreted.

Chapter 5: Discussion, conclusions and recommendations

Chapter Five contains a discussion of the results with relevance to the study objectives. The researcher concludes the research study and provides recommendations based on scientific evidence acquired during the research study.

1.13 Significance of the study

Midwives work closely with pregnant women during the labour and delivery of their babies. Communication in the labour and delivery ward is, therefore, crucial to provide a safe midwifery care (Moawed et al. 2012:406). Effective communication between the pregnant women and the expatriate midwives will prevent miscommunication and potential life-threatening incidents (Higginbottom et al. 2014:298). Expatriate midwives do communicate with Saudi patients, even though they do not speak the official Arabic language. However, these midwives come from different countries and they all have their own unique way of communicating with Saudi patients.

1.14 Summary

In this chapter, an introduction and background of the study was given. The methodology applied was briefly described. There was also an in-depth explanation of ethical considerations as well as time taken to complete the study and the outline of the various chapters as presented in the thesis.

1.15 Conclusion

Communication is an important factor in effective maternity care (Hoang, 2008:56). Although the majority of the pregnant women and their families were Saudis with Arabic as their native language, most healthcare providers, including nurses, communicated in English (Lamadah & Sayed, 2014:23), a language that most Arabic women were not proficient in. However, expatriate midwives did communicate with the pregnant women irrespective of the language difficulties.

It was important to do this research to explore the views of expatriate midwives with regard to the communication experiences that they encountered with the pregnant women so that effective maternity care could be rendered. An in-depth literature review will be conducted in the next chapter, which will emphasise the importance of communication of the expatriate midwives while caring for the pregnant women in the labour and delivery ward in Saudi Arabia.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

In chapter 1, a foundation of the study was presented. In chapter 2, a review of the literature will provide the reader with a synthesis of what is known about midwifery care in Saudi Arabia (Grove et al. 2013:40). A discussion regarding the role of communication and the communication experiences facing expatriate midwives in the midwifery practice is addressed.

The purpose of the literature review was to review the communication in a midwifery setting in Saudi Arabia, communication and the Saudi culture, communication and the maternity environment, methods of communication in midwifery, the communication barriers in maternity care, and the communication experiences of expatriate midwives with the pregnant women in the labour and delivery ward.

2.2 Selecting and reviewing the literature

The preliminary literature review was initiated prior to starting the research proposal in order to ascertain if there were any studies done on communication experiences of expatriate midwives in the Saudi Arabian setting. Several studies were found that depicted trends in midwifery care worldwide, the importance of communication in the healthcare setting and possible solutions to overcome communication challenges.

The researcher applied the principle of bracketing to set aside pre-conceived ideas about the communication experiences of the expatriate midwives.

Search engines that were accessed during the literature review were PubMed, Wiley as well as Google Scholar search engines. Resources used in the review were published within the last ten years and were obtained from peer reviewed journals and text books. Key phrases used in the literature search were: “communication in a maternity setting”, “nursing in Saudi Arabia”, and “challenges facing expatriate nurses in Saudi Arabia”. Articles depicting transcultural nursing and communication challenges in a midwifery setting in different countries were included as it provided relevant information regarding the communication experiences of the expatriate midwives.

2.3 Midwifery in Saudi Arabia

A shortage of nurses is a worldwide phenomenon (Lamadah & Sayed, 2014:20). Saudi Arabia faces a shortage of Saudi nurses due to various factors such as the lack of training centres, the need for 24 hour care with long working hours spanning day and night shifts, working not being socially acceptable by families, especially male spouses (Lamadah & Sayed, 2014:21).

The Saudi females are not allowed to drive and employing a driver increases the cost of living and therefore, females choose not to work (Lamadah & Sayed, 2014:21). To increase the nursing workforce, the Ministry of Health (MOH, 2012) recruits nurses from India, Philippines, Malaysia, South Africa, Australia and the United Kingdom (Almutairi & McCarthy, 2012:17).

Midwives recruited by the MOH speak one or more of their National languages, but at the study setting, English and Arabic are the operational languages. The majority of pregnant women spoke only Arabic and preferred the Saudi nurses as they shared the same cultural values and provided a sense of belonging to the pregnant women (Moawed et al. 2012:408). Lamadah and Sayed (2014:21) found that in the language barrier between the expatriate midwife and the pregnant women, the pregnant women preferred to be cared for by local nurses as showed in patient satisfaction surveys. A study done by Khalaf, Westergren, Ekblom, Al-Hazzaa & Berggren (2014:13-29), which researched the nurses' views and experiences of caring for malnourished patients in Saudi Arabia, found that nurses found it difficult to understand the Saudi patients even though they knew many Arabic words.

According to Lamadah and Sayed (2014:21), training Saudi nurses would bridge the linguistic communication barrier, so that patient satisfaction is promoted. Therefore, as supported by the literature, the Saudi nationals are better accepted as care providers compared to the expatriate nurses. To address the lack of Saudi nurses, the midwifery training for Saudi nurses was commenced in January 2015 – December 2016 at the study setting, which aspires to promote Saudi nurses to be employed at the labour and delivery ward at the study setting.

2.4 Communication and the Saudi culture

Culture is defined as the system of shared beliefs, behaviours, values, customs and symbols that are transmitted from one generation to another (Almutairi & McCarthy, 2012:72). It is important for the expatriate nurses to understand and respect cultural practices to gain the participation of the pregnant women and to deliver culturally congruent care. The Saudi culture is Arabic with an Islamic influence spanning more than 1 400 years since the first emergence of Islam (Almutairi & McCarthy, 2012:71).

A Muslim law, the Shariah law, underpins aspects of daily life such as family, sexuality, social issues with no tolerance for sex outside marriage (Almutairi & McCarthy, 2012:72). Therefore, all women seen in the labour and delivery ward are married, as unmarried or single mothers are not eligible for treatment. These non-eligible patients are transferred to the government hospitals by either the family member or the ambulance. The goal of the expatriate midwife is to provide care for the pregnant mother and her unborn baby, and she should not be

judgemental if unmarried mothers are placed in her care in emergency situations. Communication is thus important to maintain a good relationship with the mother.

In the Saudi culture, there is strict gender-based segregation. There is no mixing of males and females, which is evident in the labour and delivery ward as the male doctor is not allowed to examine the female pregnant women without the presence of her husband or a female staff member (Almutairi & McCarthy, 2012:72).

Shyness is one of the main behavioural traits expressed by the Saudi women (Almutairi & McCarthy, 2012:73). According to the cultural customs, the females need to be dressed properly by covering their face and body with their cultural attire. The Saudi Arabian women wear an “abaya”, a black cloak-like long dress, a “tarha”, a headscarf, and a “burka”, a facial cover which exposes only their eyes (Al-Shahri, 2002:135). The dress code is actually enforced by the Saudi men and therefore, Saudi women have to respect their decisions. The Muslim cultural aspect that expatriate midwives should consider when caring for the pregnant women is the patient’s respect for modesty, especially during examinations and procedures (Albougami, 2015:167).

Pain has both a personal and cultural meaning for the Saudi nationals, and they believe that pain have religious implications rather than a medical origin (Lovering, 2006:392-393). The Saudi nationals believe that pain or a disease is the ‘Will of God’ and provides atonement of sins and to earn a greater reward in the afterlife. Therefore, education to the pregnant women is vital to gain her cooperation and participation in her care, and effective communication is needed to educate the pregnant women.

In the Saudi culture, gender-based segregation is enforced by the society. There is no mixing of sexes, and the Saudi women are not allowed to interact with the men (Almutairi & McCarthy, 2012:72). Therefore, the pregnant women will refuse to be examined by a male doctor and this should be respected. If the male doctor examines the pregnant women, the husband or female staff should be present (Leininger & McFarland, 2002:305).

Culture plays an important role in communication, and by understanding the culture of the Saudi nationals, culturally-congruent care can be rendered to promote patient satisfaction (Khalaf, Westergren, Ekblom, Al-Hazzaa & Berggren, 2014:13).

According to Islam, the following should be considered when caring for Muslim patients (Gebara & Tashjian, 2006:387):

- Ensuring and maintaining the patient’s spirituality by providing religious material.

- Providing privacy.
- If the healthcare worker is a Muslim, she may read the Holy Qur'an to the patient.
- Keep the patient's private parts covered.
- Respect and provide privacy for religious practices like prayers or reading the Qur'an.
- The dead person's feet or soles should face the 'Qibla" (arrow indicating the direction of prayer).
- The timing of burial should be done as soon after death as possible before the last prayer of the day
- Non-Muslims may comfort a bereaved family by saying "Thanks be to God (Alhumdulillah) and '*We all come from Allah and we shall return to Him*"

The expatriate midwives must be aware of these cultural practices and respect them in order to provide culturally-congruent care to the pregnant women and enable the pregnant women to participate in her care.

2.4.1 Cultural diversity in the labour and delivery ward

Expatriate nurses working in Saudi Arabia possess diverse cultural values, beliefs, customs, behaviours and attitudes from their country of origin. These traits differ from their patients. Cultural and language differences between the pregnant women and the expatriate midwives can impact the provision of safe care (Almutairi, McCarthy & Gardner, 2015:16). Certain practices and rituals may conflict with the expatriate midwives' values and beliefs, for example, abortion and fasting during the Holy month of Ramadan. For instance, abortion is not allowed in the Muslim culture while on the other hand, abstinence from food and drinks can affect the mothers and baby's health (Leininger & McFarland, 2002:307). The expatriate midwife should not let their own beliefs influence their level of care or be judgemental of the patients' beliefs.

Cultural competence aims to improve the quality of healthcare by understanding the different cultures so that culturally-congruent care can be rendered (Almutairi, McCarthy & Gardner, 2015:18). All expatriate midwives should have cultural awareness and knowledge regarding caring for the Saudi pregnant women (Khalaf et al., 2014:13).

2.5 Communication and the maternity environment

The labour and delivery ward is a specialised department that provides maternity care to the pregnant women and the unborn baby. The environment creates a comforting and relaxing atmosphere, which has a positive impact on the birth experience (Adams & Bianchi, 2008:109). Research has shown that supporting the pregnant woman can provide positive feelings of being loved, cared for and reassures the pregnant woman, which in turn makes it a positive birth experience (Adams & Bianchi, 2008:111). Due to the policies of the study

setting, the husband and family members are not allowed to be present during the delivery and according to research, the birth experience might be compromised (Karlstrom, Nystedt & Hildingsson, 2015:251).

The expatriate midwife has the added responsibility of reassuring the pregnant woman who cannot understand her. Reassurance to the pregnant women in labour is based on verbal support on breathing techniques in labour, how to effectively push, how to relax between contraction pain, assisting the pregnant women during the labour process (Adams & Bianchi, 2008:112). The expatriate midwives need effective communication skills to give this information to the pregnant women to ensure participation and good outcomes for the pregnant women and their babies. Verbal support is an important component of communication, as this enables the woman to have a positive birth experience (Marshall & Raynor, 2014:535).

To ensure best outcomes for the pregnant women and the baby, the pregnant woman must understand what is expected from her and be allowed to participate in making decisions (Hoang, 2008:56). The pregnant woman's satisfaction is based on her freedom to ask questions, be involved in her own care, to be treated with courtesy and respect and to be understood by the healthcare worker (Newell & Jordan, 2013:77). However, due to the Saudi cultural practices, the pregnant woman are not able to make autonomous decisions without consulting her husband (Al-Shahri, 2002:136). Communication thus becomes indirect, as the pregnant woman is not involved in her own care and in emergency situations where the husband is not available, the pregnant woman's health or the baby's health may become compromised.

2.5.1 Verbal communication in maternity

The core component of verbal communication is language. The spoken word is important in midwifery care in the labour and delivery ward to create confidence and enhance the woman's childbearing experience (Lawrence, Copel, O'Keeffe, Bradford, Scarrow, Kennedy, Grobman, Johnson, Simpson, Lyndon, Wade, Peddicord, Bingham & Olden, 2012:147). Verbal communication in a multicultural, multidisciplinary team needs to be clear and clarified to ensure best outcomes for the pregnant woman and the baby.

Wilber Schramm proposed the model of communication in 1954 (Schramm's model of communication, 1954). He stated that information is meaningless unless it is put into words and conveyed to others. He also emphasised that the communication is incomplete unless the sender receives a feedback from the recipient. Schramm believed that an individual's knowledge, experience and cultural background also play an important role in communication

and individuals from diverse cultures, religion or background interpret the message in different ways. Where the sender does not get feedback, the communication is considered unclear. Wilbur Schramm's 1954 model magnifies on this thinking by highlighting the process of encoding and decoding the message. Schramm proposed this process as a reciprocal circular communication between the sender and receiver. A diaphragmatic overview of the model is depicted in the picture below:

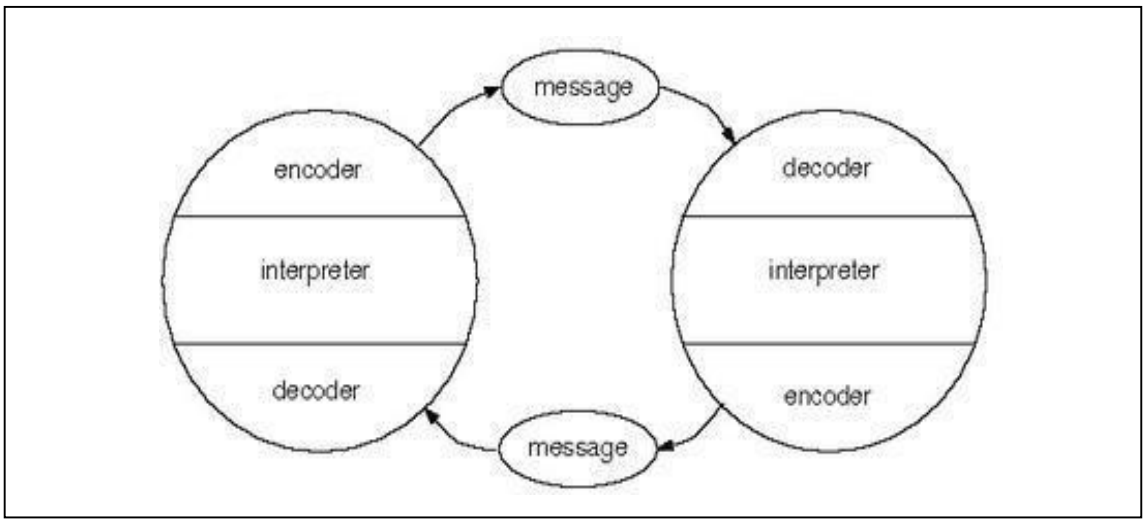

Figure 2.1: Wilbur Schramm's communication model

Source: www.commtheories.com

In the context of midwifery, the pregnant women's first encounter with expatriate midwife is in the labour and delivery ward. The pregnant women will communicate and sends the message to the expatriate midwives, either by verbal or non-verbal communication. The expatriate midwives now have to interpret the message and decode, according to Schramm's model, and provide feedback to the pregnant women to verify if the information received was understood. Through this process of communication, the expatriate midwives experience challenges to plan the pregnant woman's care.

The expatriate midwives should adopt an appropriate tone of voice that is clear and audible (Muller, 2009:227). The tone of voice can indicate sarcasm, anger, affection or confidence. Therefore, expatriate midwives must pay attention to the timing and pace, how loud she speaks, the tone and sound to make the pregnant women feel understood (Vertino, 2014:4). Constant verbal support and reassurance in labour add to the pregnant women's feelings of being understood (Borders, Wendland, Haozous, Leeman & Rogers, 2013:311-320).

2.6 Methods of communication in midwifery

Communication is the ability to transfer ideas and views from one person to another person in an understandable way (Armstrong et al., 2013:261). Communication is an interactive two-way process, and can occur by verbal, non- verbal, or face-to-face methods (Newell & Jordan, 2015:76). Communication follows a specific process and there are key elements involved. Similarly the communication in midwifery care is an interactive two-way process between the pregnant woman and the expatriate midwife using verbal, non-verbal, or face-to-face methods.

The key elements involved are the sender, message, medium, receiver, understanding and the feedback (Hetherington & Rasheed, 2013:58). The sender in this context is the expatriate midwife or the pregnant women starting the communication. The message is the information the pregnant women wishes to communicate to the expatriate midwife, or the message the expatriate midwife wishes to communicate to the pregnant women. The medium is the method of communication and this context it is the verbal, non-verbal and face-to-face. The receiver is either the expatriate midwife or the pregnant women who receives the information and interprets it. The expatriate midwife and pregnant women as receivers, have to correctly interpret the message. To close the communication process the expatriate midwife or pregnant women needs to show the sender that she has received and understood the message. The communication process is illustrated in figure 2.2.

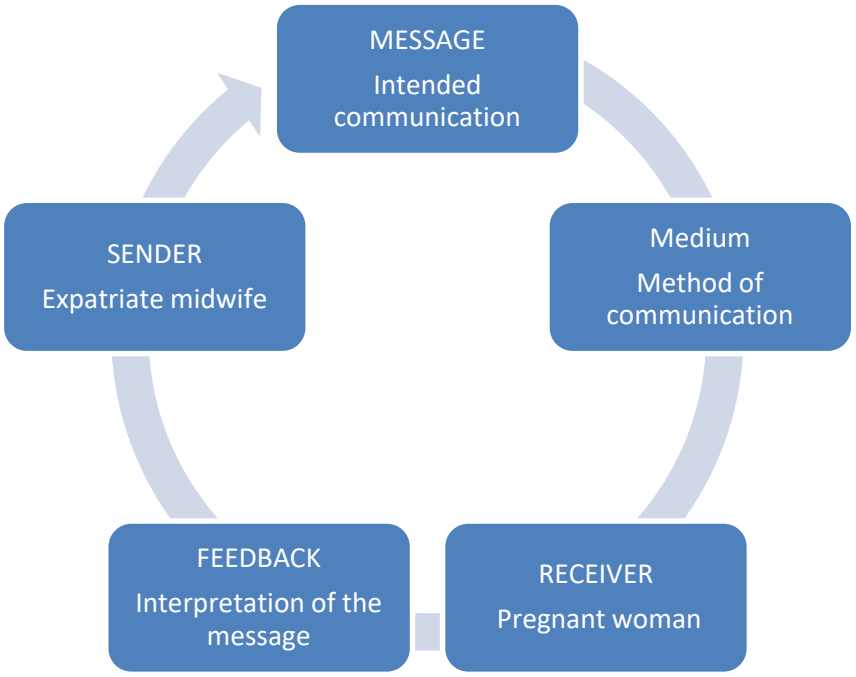

Figure 2.2: Visual representation of the communication process in the labour and delivery ward

The communication process in the maternity setting is unique as midwives play a key role in ensuring pregnant women have a safe and positive birth experience (Sengane, 2013:321).

Midwives provide support by staying with the pregnant women in labour and attending to her physical and emotional needs in all stages of labour (Moawed et al. 2012:406). The assessment of the newly admitted pregnant women in labour poses a challenge to the expatriate midwives as the complete communication process might not be followed due to the language barrier (Marshall & Raynor, 2014:334). The assessment needs to be focused and comprehensive in order for the expatriate midwife to prioritise the plan of care. In a study done by Higginbottom et al. (2015:297-304), which analysed the communication challenges in maternity care in rural Alberta, showed that miscommunication may lead to patient dissatisfaction, and even cause fatal maternal and foetal incidents. Communication between midwives and the pregnant women therefore plays a vital role to ensure the pregnant women's needs are addressed.

2.6.1 Non-Verbal communication in maternity

More than 55% of communication is made up of non-verbal messages or 'body language' (Armstrong et al. 2013:268). Non-verbal communication is a powerful tool to convey messages as it is occurs naturally, it shows the true feelings and intentions at any given moment (Segal et al., 2016:2).

There are different types of non-verbal communication namely posture, facial expressions, eye contact, appropriate use of touch and space and body gestures (Hetherington & Rasheed, 2013:60). Facial expressions of happiness, sadness, anger, surprise, fear and disgust are uniform across all cultures (Vertino, 2014:3). It is important to note that the Saudi nationals use non-verbal communication modestly and expatriate midwives need to understand this from a cultural point of view to provide culturally congruent care (Almutairi & McCarthy, 2012:72). The pregnant women are dressed in cultural attire, the abaya, burka and hijab that hide their non-verbal language, except for their eyes. The hidden non-verbal language challenges the expatriate midwife to gain information from the pregnant women's eyes until her hijab is removed. Expatriate midwives should show concern and warmth by using relevant non-verbal gestures such as nodding of the head (Muller, 2009:227).

Communication in the labour and delivery ward is primarily non-verbal as expatriate midwives are not fluent in the Arabic language (Halligan, 2006:1569). Halligan studied the critical care nurses' experiences in caring for Islamic patients in Saudi Arabia (Halligan, 2006:1565-1573). Expatriate midwives should try to maintain eye contact with the pregnant women while understanding the cultural practices (Muller, 2009:227). Due to the Muslim culture, a female nurse cannot make eye-contact with the male or spouse, as this is not allowed. This shows interest, affection, attraction or hostility (Vertino, 2014:3).

2.6.2 Communication in building trust-relationship

Good communication plays an important role between the pregnant women and the expatriate midwife. A study by Rowe, Garcia, McFarlane & Davidson (2002:63-83), which investigated the communication between health professionals and women in a maternity care setting, women preferred smaller number of caregivers, and being able to build relationships over time and be involved about decisions regarding their care. This leads to the pregnant women having trust in their caregiver, which will, in turn, lead to a positive birth experience.

Effective communication between pregnant women and expatriate midwives is important so that the pregnant women's feelings and symptoms can be understood by the expatriate midwife, hence, the pregnant women can understand her treatment plan (Higginbottom et al. 2015:298). This increases the pregnant women's trust in the expatriate midwife, and she can participate in her care and make good decisions for herself and her unborn baby (Marshall & Raynor, 2014:534-535).

To establish trust, expatriate midwives must be cognisant that the first encounter is core to a positive relationship between her and the pregnant women (Karlstrom et al., 2015:4).

2.7 Factors that impact communication in maternity

There are certain factors that impact effective communication. These factors can be physical barriers, environmental factors and language and communication difficulties.

2.7.1 Physical barriers

Physical barriers in communication with the pregnant women are impaired sight, speech or hearing. Impaired mental status and emotions such as fear, anger and anxiety can also negatively influence the understanding of the message (Armstrong et al*.,* 2013:264). Pregnant women often present with fear and anxiety due to hosptialisation. This also will affect the way in which they will communicate to the expatriate midwives.

2.7.2 Environmental barriers

Environmental factors like a stressful, noisy environment can impact the understanding of the message (Armstrong et al*.,* 2013:264). The labour and delivery ward can be seen as a noisy environment because patients have increased amounts of pain during childbirth, where they are found to be screaming due to their heightened pain. The heightened pain especially in the second stage of labour demands the expatriate midwife to stay patient and calm as the pregnant women in labour might not participate in her care.

2.7.3 Language barrier

Language and communication difficulties seem to be a common factor affecting healthcare workers around the world, where healthcare workers do not speak the same language as their patients. Timmins (2002) looked at the language barriers impacting the healthcare of Latinos in the United States, where healthcare workers had difficulty in communicating in the official Spanish language. The conclusion was to have effective bilingual interpreters to assist with communication barriers (Timmins, 2002: 80-96). In another study done by Hoang (2008:55-61), which addressed the language and cultural barriers accessing maternity care in Australia, it was found that having interpreters could solve the language problems. Another study done by Mebrouk (2008:149-161), emphasized the positive impacts on patient care and increased patient satisfaction by using the Arabic language for communication between patients and local nurses.

The use of interpreters assists healthcare workers to communicate with patients where there is a language barrier between healthcare professionals and patients. Interpreters could be a healthcare professional, family member, friend or colleague that understands the patient and the target language (Armstrong et al., 2013:274).

There are certain advantages and disadvantages when using interpreters. The use of interpreters will improve the patient's understanding and they can participate in their care. However, confidentiality will not be maintained and the information may not be accurately interpreted (Armstrong et al. 2013:274).

A study conducted by Renata, Meuter, Gallois & Hocking (2015:1024-1028), which studied the language barriers in communicating with Chinese patients, found that clinicians needed communication training to treat patients effectively. Similarly, in another study done by Al-Harasis (2013:1-7), which studied the impact of the language barrier in hospitals in Saudi Arabia, it was noted that the administration of Arabic courses for nurses was essential. This could increase the quality of healthcare that was provided. Al-Harasis also found other solutions to improve the language barriers such as using a common words dictionary by patients and staff members, using non-verbal communication such as hand gestures and facial expressions, and having translators in different departments. In a study which was done by Halligan (2006:1565-1573), the critical care nurses' experiences were studied in Saudi Arabia, and it was noted that all expatriate nurses were given Arabic language courses to increase their communication skills with Islamic patients.

A study done in Alberta in 2014 that examined the communication challenges in maternity care for immigrant woman, found that cultural factors influenced communication. It was the

responsibility of the organisation to equip healthcare workers with the necessary skills to deliver culturally appropriate care (Higginbottom et al. 2014:297-304). Similarly, expatriate midwives provide care to pregnant women. They should be trained in cultural awareness and skills to care for the Saudi pregnant women. Maternity care can be compromised if the pregnant women do not understand the information given by the expatriate midwife. The use of non-verbal communication is important in these situations where there is a language barrier (Higginbottom et al., 2014:298).

A systematic review done by Newell and Jordan (2015), which examined the patient experience of patient-centred communication with nurses in a hospital setting, found that nurses undertake duties with patients in a face-to-face manner with the patient at the bedside and these moments can facilitate effective interaction to occur between the nurse and the patient (Newell & Jordan, 2015:76-87). In the maternity setting, expatriate midwives monitor the pregnant women closely in labour. If the pregnant women and the expatriate midwife spoke the same language, understanding of her condition and treatment would be easier and this would lead to increased patient satisfaction in her care.

In another study done by Almutairi (2015), he examined the culture and language differences as a barrier to the provision of quality care by the health workforce in Saudi Arabia. He stated that healthcare workers believe that communication is more effective when it is responsive to patient needs, values, and preferences (Almutairi, 2015: 426). He also stated that factors influencing communication include cultural differences, low health literacy, and language differences. He found that language barriers affect communication in Saudi Arabia and this can compromise the quality of healthcare (Almutairi, 2015:428). The expatriate nurses should, therefore, be kind and provide information in a manner that the pregnant woman can understand, so that trust between the expatriate midwife and the pregnant woman can be promoted (Kourkouta & Papathanasiou, 2014:66).

2.8 Summary

There will always be challenges to communication when people do not speak the same language, however, ultimately communication does take place with the assistance of, for example, interpreters. Having various solutions and processes in place can mend the communication gaps identified by the literature as experienced by the expatriate midwives and pregnant women. Even though communication is a worldwide challenge, maternity care and treatment is provided and the goal of healthy mother and baby is achieved.

2.9 Conclusion

In this chapter a review of the literature was given. The role of communication in midwifery, communication and the Saudi culture and the barriers were addressed. The midwifery in Saudi Arabia was then discussed with the emphasis on the Saudi midwife and the expatriate midwife. Communication plays a crucial role in the provision of maternity care to pregnant women. The purpose of this study was to explore and describe the communication experiences encountered by the expatriate midwives with the pregnant women.

The chapter that follows provides a description of the research methodology used to explore the communication experiences of expatriate midwives in a military hospital in Saudi Arabia.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

This chapter describes the research methodology that was used to achieve the set objectives of the study. Accordingly, the population, data collection, trustworthiness and ethical considerations are described. All these steps form part of the research process and are logically connected to each other as well as to the theoretical foundation of the study (Burns & Grove, 2007:31).

3.2 Aim and objectives

The aim of the study was to explore and describe the role of communication of the expatriate midwives while caring for the pregnant women in the labour and delivery ward of a military hospital in Saudi Arabia. The objectives of the study were to:

- Describe communication of the expatriate midwives while caring for the pregnant women in the labour and delivery ward of a military hospital in Saudi Arabia
- Explore the communication experiences of the expatriate midwives while caring for pregnant women in the labour and delivery ward of a military hospital in Saudi Arabia

3.3 Study setting

The setting is the location where a study is conducted. The natural setting is an uncontrolled, real-life situation or environment where the researcher does not manipulate or change the environment for the sake of the study (Grove, Burns & Gray, 2013:373). In a natural setting, people carry out activities of daily life such as working, playing or whatever phenomenon is under investigation (Taylor, Kermode & Roberts, 2006:200). This descriptive study took place in its natural setting.

This study was conducted at one of the Saudi Arabian military hospitals situated in the Eastern Region of Saudi Arabia. It is a 222-bedded hospital which provides care to military personnel and their dependants. A military hospital has a programme director who is in charge of the organisation, and has no medical expertise. The nursing director falls under the leadership of the programme director, and cannot make decisions without the programme director's authorisation. The nursing director is the ultimately in charge of the labour and delivery ward with the manager as the head of the department. The labour and delivery ward of the hospital employed midwives from other countries such as South Africa, Malaysia, Philippines, United Kingdom, Canada, United States and India. The official languages spoken at the hospital are English and Arabic. These languages can be verbal, or written. The written languages are in the form of memos, policies, medical and nursing records. All written material, which include

patient records, procedure guidelines and policies are written in English to ensure consistency is maintained across the multicultural workforce.

The target population comprised of all expatriate midwives working in the labour and delivery ward who came from different countries as stated above. They worked with each other and the clients in the labour and delivery ward. The setting was natural as the researcher did not intervene in their environment during the research process. The interviews were not conducted on site where the participants worked.

3.4 Research design

Polit and Beck (2004:49) refer to the research design as the "architectural backbone of the study" with the goal to answer the research question and to eliminate or minimise errors. The research design is a strategic framework for the execution or implementation of the research process (Blanche & Durrheim, 2004:29). It guides the researcher to obtain the intended information (Burns & Grove, 2001:223). The design identifies the individuals to be studied where, when and under what circumstances (McMillan & Schumacher, 2001:166).

Choosing a design depends on the problem and purpose of the study and the intent to generalise the findings (Burns & Grove, 2007:38). The design utilises techniques that enable the researcher to gather and analyse data systematically (Polit & Beck, 2004:731).

In this study, the research followed a qualitative approach with an exploratory descriptive. According to Burns and Grove (2011:73), qualitative design describes the life experiences of participants and the researcher tries to gain meaning from these experiences. By using an exploratory-descriptive approach, the problem can be addressed with the aim of finding a solution (Grove et al., 2013:66). In this context, the problem of communication experiences between the expatriate midwives and the pregnant women in the labour and delivery ward in Saudi Arabia were identified, and possible solutions were explored.

Descriptive research accurately describes a situation or group (Grove et al., 2013:26). Descriptive studies encourage the researchers to find new meanings of the situations and describes the current situation (Grove et al., 2013:26). In this study, the researcher described the communication experiences of the expatriate midwives with the pregnant women in the labour and delivery ward, as it existed in their work environment at that time.

Descriptive designs are used to identify problems in the current practice or investigate what other people experience in similar situations and there is no treatment or interventions that are used to require this information (Grove et al., 2013:215). In this study, the research question did not suggest an intervention, rather to explore and describe the communication experiences

of the expatriate midwives with the pregnant women in the labour and delivery ward in Saudi Arabia. Descriptive studies identify an area of concern that needs to be studied (Grove et al., 2013:217). The researcher noticed that the expatriate midwives had different communication experiences with the pregnant women in the labour and delivery ward of Saudi Arabia.

Expatriate midwives provide maternity care to all pregnant women in the labour and delivery ward. Communication begins at the first point of contact when the pregnant women enters the labour and delivery ward, and ends after the birth of the baby. Expatriate midwives spend lots of time with the pregnant women during the different stages of labour, providing treatment and informing her about her plan of care. Through all these processes, communication between the expatriate midwife and the pregnant women needs to be clear and understandable. Even though the expatriate midwives do not speak the Arabic language of the pregnant women, care is still provided by means of their own unique communication style. By doing a qualitative descriptive study, expatriate midwives were interviewed to explore their communication experiences with the pregnant women and how this affected them in their workplace.

3.5 Population and sampling

The population includes all elements of individuals, objects, events, or substances that meet the study criteria (Burns & Grove, 2007:40). The population that is selected should be able to answer the research question (Taylor et al., 2006:201) and is called the target population (Taylor et al., 2006:201).

In this study, the target population comprised all the expatriate midwives working in the labour and delivery ward of a military hospital in Saudi Arabia. There were 15 expatriate midwives working in the labour and delivery ward at the time of the study.

Sampling involves selecting a group of people with which to conduct a study (Grove et al., 2013:351) from the target population. The aim of sampling is to select people that can represent the population that the researcher wants to study (Blanche & Durrheim, 2004:44). In this context, the group of people selected were the expatriate midwives as they could not communicate to the pregnant women in Arabic.

Purposive sampling was selected by the researcher for this study. Purposive sampling is referred to as selective sampling (Grove et al., 2013:365). Here, the researcher selected all participants to be included in the study. The expatriate midwives provided midwifery care to all the pregnant women and they had unique communication experiences in the labour and delivery ward.

The sample size refers to the number of individuals participating in the research study (Grove et al., 2013:371). The sample size was small due to the relatively small population size. The purposive sampling method in this qualitative research study aimed to understand the communication experiences of the expatriate midwives in the labour and delivery ward (Grove et al., 2013:365).

There were 15 expatriate midwives who worked in the labour and delivery ward of the hospital and worked both day and night shifts. A verbal explanation of the study was given to all 15 expatriate midwives by the researcher during their ward meeting, which was held in the labour and delivery ward in August 2015. Permission was granted verbally by the manager of the labour and delivery ward to inform the expatriate midwives regarding the study. During the information session by the researcher, an information sheet was given to all the expatriate midwives regarding the study.

The majority of the expatriate midwives approached to participate did not feel the need to participate in the study, due to personal reasons. In-depth explanations of the aim of the study, both to the expatriate midwives and the organization, were explained by the researcher for a second time, two weeks after the initial information was given, hoping that more participants would participate in the study. However, it did not avail anymore participants.

Seven (7) participants who were all expatriate midwives volunteered to participate in the study. Two (2) midwives had to go on emergency leave to their country of origin at the time of the data collection after they had consented to participate in the study. Those two midwives were physically unavailable to participate in the study. They were not coerced to participate in the study and they were free to withdraw from the study at any time. This reflected their right to fair treatment.

The participants placed their names and contact numbers on a piece of paper in a postbox which was locked and was kept in the labour and delivery ward. The postbox was available in the ward for a week. All seven names placed in the post box were interviewed by the independent field worker. The decision of the remaining expatriate midwives who did not volunteer to participate in the study, was respected.

3.5.1 Inclusion criteria

Inclusion criteria are the traits of communication experiences that the expatriate midwives possessed which were included in the target population (Grove et al., 2013:353).

In this study, the researcher included all 15 expatriate midwives working in the labour and delivery ward of a military hospital in Saudi Arabia.

There were no exclusion criteria as all midwives were expatriate midwives.

3.6 Interview guide

An instrument is a component of measurement which applies specific rules for development (Burns & Grove, 2007:40). A semi-structured questionnaire (interview guide) was the data collection instrument for this study.

The researcher-developed interview guide was developed by the researcher by focusing on the communication experiences of the expatriate midwives. The interview guide was reviewed by the study supervisor and co-supervisor to ensure applicability to the study. The interview guide was also tested in the pilot interview. A semi-structured interview was carried out in which open-ended questions were used (Appendix 1).

The researcher-developed questionnaire comprised 3 questions. The first question was: “How do you communicate with patients in the labour ward?” This was an open-ended question which encouraged the participants to give more in-depth information.

The second question was: “Why is it important to communicate with patients in the labour ward?” Interviewing skills such as probing was used. The field worker probed and used other questions like why, tell me more, how does that make you feel?

The last question was: “Do you have suggestions for communication?” This was a open-ended question whereby the participants had to give suggestions to improve communication in the labour and delivery ward. Probing and clarifying the responses used by the field worker was important to gain more information to the question.

The expatriate midwives were given the opportunity to verbalise their experiences in communicating with the pregnant women in the labour and delivery ward. This was important as each midwife had different experiences regarding the communication, because some midwives had worked for a longer period in Saudi Arabia and others were new nurses that had come to the Kingdom. The spoken words served as data during the interview. The participants were contacted telephonically by the independent field worker to arrange a date and time for the interview.

3.7 Pilot interview

A pilot interview is conducted prior to the main study. It is done to explore the practical aspects of the main study. It is done with participants who meet the inclusion criteria for the main study and data obtained from the pilot interview may or may not be included in the main study (Brink et al., 2012:174).

A pilot interview was conducted by the independent field worker and a participant who met the inclusion criteria. The participant was an expatriate midwife who worked in the labour ward for three years. The interview was conducted at the participant's accommodation during her off-duty time by the field worker, as her place offered a sense of comfort and familiarity. The interview guide was used by the independent field worker to conduct the interview.

The transcript and the audio recording were reviewed by the study supervisor. The study supervisor suggested that the field worker probed more detail in the second question of the interview guide, however, the data was sufficient. She also suggested that the field worker keeps accurate field notes. The interview was recorded by the field worker by means of a voice-recorder. The voice recording was transferred and saved on the computer as a password protected audio file. This was sent by email from the fieldworker to the researcher, which was then emailed to the study supervisor and was reviewed. The data was added to the findings as part of the data analysis as it was found to be of adequate quality.

3.8 Trustworthiness

Trustworthiness is a method of ensuring quality data is being collected in qualitative research. Lincoln and Guba (1985) suggested four criteria for trustworthiness of a qualitative inquiry: credibility, dependability, confirmability and transferability (Polit & Beck, 2012:584) which will be explained below.

3.8.1 Credibility

Credibility refers to the truth of the data and the process of interpreting the data (Polit & Beck, 2012:585). The audio-recorded interviews and transcripts were sent to the study supervisor to be analysed, to ensure the data in the interview and transcripts correlated and were a true reflection of the data collection process. The researcher and study supervisor listened carefully to each of the audio-recorded interviews while making reflective notes prior to the coding process. Transcripts were read and re-read by the researcher and the study supervisor to make sure all data were included in the study.

Interviews were coded by the researcher and reviewed by the study supervisor to ensure credibility of the data. Two interviews were co-coded by the researcher and study supervisor to ensure that the coding was correct. The researcher also kept an audit trail by using different coloured pens to highlight similar verbatim quotes. This showed how the themes and sub-themes were chosen. The study was also supervised by an expert in research methods and midwifery.

The researcher made use of bracketing to ensure credibility of the research findings. Bracketing is a process whereby the researcher set aside her pre-existing knowledge regarding communication with the pregnant women in the labour and delivery ward (Grove, Burns & Gray, 2013:6). This was achieved by ensuring a field worker was used to conduct the interviews who had no expertise in midwifery, nor did she work at the study setting. In this way, the researcher did not influence the process of data collection in any way. Bracketing further occurred through debriefing sessions with the researcher and the study supervisor.

Member checking was also done to ensure credibility of the data. Member checking is when the researcher takes the transcripts of the interview back to the participant and allows the participant to confirm the accuracy of the information collected during the interview process (Brink et al., 2012:172). In this way, the truth of the data is ensured. In the present study, the researcher was able to perform member checking with two of the participants as the other participants were not available at that time, as some had returned back to their country of origin. The interpretation of the findings such as themes, were presented to the participants and sub-themes were discussed to verify whether the interpretation was true. The participants agreed to the interpretation of the themes and sub-themes

3.8.2 Transferability

Transferability refers to the degree in which the findings can be applicable in other settings or groups (Polit and Beck, 2012:585). Transferability was enhanced giving a thick description whereby the researcher provided an in-depth discussion of the research methodology and the findings. The researcher provided the same study setting to all participants so that the differences within settings could also be controlled for. Future researchers wishing to conduct similar studies in the context of communication experiences of expatriate midwives in the labour and delivery ward of Saudi Arabia, will be responsible to decide on transferability.

3.8.3 Dependability

According to Polit and Beck (2012:585), dependability refers to the reliability of the data over time and conditions. It also relates to how stable the data can be over a period of time (Brink et al., 2012:171). The researcher ensured that all six steps in the data analysis process according to Creswell (2014:247-250) were well documented to allow the data to be clear and dependable. The same interview guide and interviewer was used for all interviews. Transcripts and audio-recorded interviews were checked and verified by the study supervisor. The study supervisor also guided the researcher during the progression of the study. She analysed and evaluated decisions made by the researcher to ensure the trustworthiness of the study.

3.8.4 Confirmability

Confirmability refers to the degree to which the results could be confirmed by others (Polit and Beck, 2012:585). It also refers to the truth in the findings of the study, ensuring the findings are not based on the biases of the researcher (Babbie and Mouton, 2011:278). The researcher attempted to make sure that the data provided by the participants were accurate by recording the data during the interview process. All transcripts were verified by the researcher and the study supervisor to ensure confirmability. The researcher also kept an audit trail of how the themes and sub-themes were decided upon. The participant's verbatim quotes were used to report the data to substantiate the themes identified.

There should be no evidence of any bias from the researcher (Brink et al., 2012:173). The researcher's bias was minimised as an independent field worker from another hospital conducted the interviews, which made the participants able to freely express their experiences of communicating with pregnant women in the labour and delivery ward. The researcher made use of reflective thinking by putting aside her own feelings and prejudices when the data was analysed.

3.9 Data collection

Data collection is an orderly and systematic process by obtaining information which is relevant to the aim and objectives of the research study (Grove et al., 2013:45). Data collection is a process that focuses on the what, how, who, where and when (Brink et al., 2010:147).

Permission to conduct the study was granted by the Health Research Ethics Committee of the University of Stellenbosch prior to commencing data collection. Permission to conduct the study at the study setting was also granted by the Ethics Committee of the military hospital in Saudi Arabia. After the participants volunteered to participate in the study, the list of participants, including contact numbers, was given to the independent field worker by the researcher.

Data collection occurred through individual interviews as the expatriate midwives worked both day and night shifts and it was difficult to have them in a group at the same time. The interviews were conducted by the field worker using a semi-structured interview guide. Interviews are verbal and non-verbal interactions that occur between the research participant and the researcher that produce data in the form of words. Semi-structured interviews are interactions that are conducted around a specific set of open-ended questions (Grove et al., 2013:271). Face-to-face interviews were carried out by an independent field worker as the researcher worked at the same hospital as the study setting. The ethical principle of confidentiality was

maintained as the privacy of the participants were kept confidential. No names of the participants were used which also ensured confidentiality.

The independent field worker was a clinical instructor who worked in another military hospital in Dammam. She had a Master's degree in nursing from South Africa and had experience with conducting research interviews. The field worker was familiar with the topic of the study as she had a qualification in Midwifery. The field worker's home language is English. The researcher trained the field worker in a 2-hour training session at the researcher's place of accommodation prior to conducting the interviews. The researcher ensured the field worker was fully prepared and engaged in the communication principles under study. By utilising an independent field worker from another hospital, the participants had a right to fair treatment without fear of prejudice and blame.

The researcher was employed as a clinical instructor in a management role at the study setting. The participants knew the researcher as she worked at the study setting and this might have caused feelings of insecurity if the researcher conducted the interviews. Bias was thus minimised during the interview process as the researcher was absent during the interviews. The participants had a right to withdraw from the study at any time giving them a sense of autonomy and maintaining their right to self-determination. Their autonomy was also enhanced by signing an informed consent prior to the study.

The independent field worker contacted the participants and arranged a date, time and a venue for the interview. Participants were interviewed during their off-duty time at their accommodation, which was outside of the hospital premises so that they felt comfortable. The interview schedule did not exceed one hour for each participant.

The ethical principle to maintain privacy was achieved, as the independent field worker and participant were alone at the participant's residence. The participants were also protected from discomfort and harm by being interviewed at their accommodation and by being in a comfortable surrounding. The independent field worker travelled to the participant's accommodation at their convenience. Transport allowance for the independent field worker was provided by the researcher.

Each participant signed a written informed consent prior to the interview. The audio of the interviews were then digitally recorded. All the participants were interviewed in English, as this is the professional language spoken by all expatriate staff in the military hospital of Saudi Arabia. Due to English not being the expatriate midwives' first language from their country of origin, the field worker had to repeat certain questions to gain clarity of the participants. A

standardised interview guide was used for all participants. The informed consent and the demographic data were verified by the independent field worker and the participant prior to the interview.

The audio-recorded files were digital and were transferred to the computer. The audio files were transferred from the field worker's computer to the researcher by electronic mail. The data on the field worker's device were immediately deleted after being transferred to the computer. The data on the computer was protected by a password and only the researcher had access to this password. The field notes that were written during the interviews were hand delivered in a sealed envelope from the field worker to the researcher at the researcher's accommodation. The ethical principle of maintaining privacy and confidentiality was thus maintained.

The independent field worker conducted individual face-to-face interviews with participants, to ensure that optimal data was collected. After introductory pleasantries, the independent field worker explained the purpose of the study, the expected time required, the confidentiality of the information and the role the participant would play in the interview. The participant was informed that the interview would be recorded by using an electronic voice recorder and a cell phone voice recorder would be used as a back-up for the interview. The participants consented to these recordings. The participant was then informed that she could withdraw from the interview at any time and that her participation was voluntary. To create an easy atmosphere and to reduce anxiety, participants were offered refreshments such of coffee/tea and cake prior to the interview.

Interviews carried out were between 30 and 45 minutes in duration. Interviews took place at the participant's residence, in a private room, away from noise and distraction. This also enhanced the participant's right to privacy and confidentiality. Data collection happened from September 2016, one month after the pilot interview, to November 2016.

3.10 Data analysis

Qualitative data analysis is a process of examining and interpreting the data in order to gain meaning, understanding and knowledge (Grove et al., 2013:279).

The procedure used for data analysis was Creswell's six step method (Creswell 2014:247-250). These steps are explained below:

3.10.1 Step 1: Organise and prepare the data for analysis

This involves transcribing interviews, typing up field notes, sorting and arranging the data (Creswell, 2014:247). The researcher transcribed the interviews herself, manually on the computer. Transcribing was done as soon as the field worker sent the data from the interview to the researcher by electronic mail, so that accurate data could be obtained. The transcripts were labelled by a number such as participant 1, participant 2, and up to participant 7. All the audio files that were password protected were saved under the “Dropbox” application on the computer as the data was big and occupied space on the computer memory. An example of a portion of transcript is provided as Appendix 5.

3.10.2 Step 2: Read or look at all the data

This step provides a general sense of the information and an opportunity to reflect on its overall meaning. The researcher read through the transcriptions and compared the transcriptions to the audio recordings. Transcriptions were read and re-read to gain a sense of the meaning of the interview.

Bias was minimised by having a field worker to conduct the interviews. The field worker had no expertise in midwifery, nor did she work at the study setting. In this way, the researcher did not influence the data analysis process.

The researcher made use of bracketing to ensure credibility of the data by acknowledging her opinions and making sure they do not impact the data analysis process. Bracketing further occurred through debriefing sessions with the researcher and the study supervisor. The researcher, therefore, did not influence the participants of the interview process in any way.

Member checking (participant validation) was also done with two participants, as the other five participants were not available at the time. The interpretation of the findings, which were the themes, sub-themes and formulated meanings of the participant’s verbatim quotes were taken back to the participants and they agreed with the interpretation of the data. This ensured credibility of the data.

3.10.3 Step 3: Start coding all of the data

Coding is the process of organising the data into groups, it is the labelling of words or phrases in the data (Grove, Burns and Gray, 2013:281). Codes that came directly from the data were used. This was done manually on paper.

Paper trails were established using a highlighter colour pen for codes on hard copies of the transcribed interviews. The significant statements identified in the transcripts were manually

highlighted in-text. Common codes emerged and were identified, these where entered into a table format using a word document that was copied from the electronic transcripts. One column was used for the codes, the other column included the verbatim data of the participants. Co-coding was done by the researcher and the study supervisor for two of the transcriptions to ensure data was analysed and coded correctly. The coding was verified by the supervisor for all transcriptions to ensure credibility.

3.10.4 Step 4: Use the coding process to generate a description of the people as well as identify themes from the coding

Description involves the analysis of the information from the data in which the codes can be used for the narrative research studies (Creswell, 2014:249). The codes were then grouped into themes and sub-themes by manually highlighting the common codes within the table created with the verbatim text on the one side and the codes on the other (discussed in step 3). These themes and subthemes where further refined on discussion with the study supervisors, who had studied the table with the codes and related verbatim text in-depth.

3.10.5 Step 5: Represent the data within a research report

The research report reflects the findings of the data analysis of the study (Creswell, 2014:249). The resulting themes were presented by the researcher in a narrative form by integrating the emerging themes and formulating meanings into a description that creates an overall structure that contains all the essential elements of the study. The narrative form was sent to the study supervisor for validation. Several drafts of this report manifested as the themes and sub-themes became more refined during this process.

3.10.6 Step 6: Interpret the larger meaning of the data

This step interprets the findings or results. The themes and sub-themes were described in context and redundant and misused descriptions were removed from the overall structure. The researcher used coding maps to code the transcripts. The codes that were not highlighted were removed from the sub-themes as the data was not useful to the study. The results will be discussed in Chapter 5 with a reflection of the literature.

3.11 Summary

In this chapter, the research methodology that was applied in the research study was discussed as well as the research process that was used. The chapter that follows will focus on the presentation of the findings that resulted from the study.

3.12 Conclusion

A qualitative descriptive design was used to explore the views on communication amongst expatriate midwives in Saudi Arabia. This design also guided the manner in which data was analysed and presented to provide a clear picture of the study. In Chapter four, the findings are presented and interpreted.

CHAPTER 4: FINDINGS

4.1 Introduction

In the following chapter the study findings will be presented and discussed. The audio recorded interviews were manually transcribed verbatim by the researcher, on the computer directly into a Word document. Interviews were analysed in order to describe the communication experiences faced by the expatriate midwives working in the labour and delivery ward in a military hospital in Saudi Arabia. Various quotations from interviews are included within the narrative to verify the trustworthiness of the findings presented. Analysis of the data was based on the approach using Creswell's six step method (Creswell, 2014:247-250) as described previously in Chapter 3.

The researcher identified four major themes from the responses of the participants during the interviews. The themes that emerged were: the different methods of communication in the labour and delivery ward, the communication challenges, the importance of communication, and the solutions for better communication in the labour and delivery ward. Data is represented in two sections. Section A described the biographical data gathered at the beginning of each interview. Section B follows with the themes that emerged during the data analysis of the interviews.

4.2 Section A: Biographical data

The sample for the study consisted of seven participants as this was the number of willing participants who indicated they would like to take part in the study. One of these participants was interviewed in the pilot study, as the interview provided data that was critiqued by the supervisor and found to be consistent for use. All the participants were female. All the participants were expatriate midwives who worked in the labour and delivery ward of a military hospital in the eastern region of Saudi Arabia. The participant's experience working in Saudi Arabia for this hospital ranged from 2 years to 8 years. The participant's ages ranged from 36 years to 50 years. The participants all had varying home languages, none of which were Arabic. These languages included English, Afrikaans, Malay, Tagalog and Malayalam.

4.3 Section B: Themes emerging from the interviews

The formulated themes and sub-themes are represented in Table 4.1. Each of the emerging themes is discussed under a separate heading. Table 4.2. represents the sub-themes and the formulated meanings from the participant's direct verbatim quotes. The formulated meanings were derived from the codes in the data.

Table 4.1: Themes and sub-themes

	Sub-themes
Communication methods	Verbal non-verbal
Communication challenges	Different dialects of Arabic; Cultural constraints; Lack of patient's birth experiences
Communication rationale	Gain patient's participation; Allay patient's anxiety; Increase patient's trust in the midwife; To educate patients
Communication solutions	Employ interpreters; Arabic-English classes; Provide patient education in antenatal; Provide communication resources

Table 4.2: Sub-themes and formulated meaning

SUB-THEMES	FORMULATED MEANINGS
Verbal	Communication in English & Arabic Communicate in broken Arabic Arabic used, broken with English Verbal attempted, there's language barrier
Non-verbal	Communicate with facial expression Use sign language Use body language Women taken in private to unveil face Patient holds abdomen due to pain Initially relied on signs
Different dialects of Arabic	Patients speak different Arabic Arabic different from rural to urban areas Some patients speak fluent Arabic Patients from North speak different Arabic
Cultural constraints	Patients don't want male doctors Saudis can explain well in their language Cannot unveil their face Prefer expats due to culture & privacy Some request South African/ Malaysian
Lack of patient's birth experience	Patients not educated Patients not experienced Especially preemies not educated, are scared Refuse treatment

Gain patient's participation	To create a conducive environment If nurses speak Arabic, patients will feel comfortable They will express themselves Create rapport
Allay patient's anxiety	Patients are scared and stressed Anxious, don't understand the midwife Disturbs labour if patient is anxious Patients scared of expats- don't know Arabic Environment is disturbed
Increase patient's trust	Not knowing Arabic, can't build trust relationship Patients feel safe if midwife can speak Arabic Patients are more comfortable If patients don't trust the midwife, they are not relaxed Patients request certain midwives from previous deliveries, due to trust
To educate patients	Patients don't know the labour process Need to educate her about procedures Have to make her understand her treatment If they understand, delivery runs smoothly Need to give health education
Employ interpreters	Have interpreters in L & D Interpreters to be on every shift Have interpreters in MCH
Arabic/English classes	Have Arabic/English classes during orientation Need basic lessons in Arabic/English
Provide education in antenatal	Education needed in MCH Patients are educated when they come to L & D No education in MCH, patients not prepared for delivery
Provide communication resources	Dictionary with basic words for L & D Computers with pictures translated in Arabic Pamphlets Little cards to pictures in Arabic

4.3.1 Theme 1: Communication methods

Different communication methods ensure that the pregnant women have a safe and supportive care in labour, and this includes verbal and non-verbal communication methods (Marshall & Raynor, 2014:334).

Generally, in Saudi Arabia, the English language is not spoken very well amongst the Saudi nationals or the expatriate population, as it is neither's first language from their country of origin. The expatriate population, in this context the labour and delivery ward, speak their native language from their country of origin, e.g. the Malaysians speak Malay, Indians speak

Tamil/ Malayalam, Philippines speak Tagalog and South Africans speak English/Afrikaans/Zulu/Xhosa/other. These languages are spoken outside of the labour and delivery ward. In the labour and delivery ward, the participants spoke English and Arabic during patient care and patient handovers. Saudi nationals in the study setting are pregnant women, doctors, student midwives and administrative staff who are fluent in the Arabic language.

English and Arabic are the recommended languages for all clinical and non-clinical hospital staff, as stipulated in the hospital policy. The Saudi nationals communicated in Arabic with one another. This language discrepancy caused a communication barrier for participants as they cannot communicate fluently in Arabic. They shared feelings about the Saudi patients' willingness to communicate even though they didn't speak fluent English.

All participants indicated that they used both methods of communication, namely verbal and non-verbal communication. All participants stated they used both the English and Arabic languages for verbal communication, and they used body gestures for non-verbal communication. Each participant reflected on their own communication style depending how comfortable they felt with the Arabic language.

The participants spoke little to no Arabic, when midwifery care was provided to the pregnant women. This language discrepancy caused a communication barrier for participants as they cannot communicate in Arabic fluently. They shared feelings about the pregnant women's willingness to communicate even though they didn't speak fluent English:

> *"We do use both methods of communication, verbal and non-verbal, but it is very difficult as expatriates with the language barrier."* (Participant 7)

The participants indicated the use of non-verbal communication methods such as gestures and facial expression specifically with the pregnant women.

4.3.1.1 Sub-theme 1: Verbal

Research shows that verbal support to pregnant women in labour by midwives increased their participation in their care (Borders et al., 2013:311-320).

Participants tried to use verbal communication to communicate with the pregnant women. English was the first language for four of the participants; three participants were not fluent in the English language. The latter also used broken English to communicate with the other professionals in the ward. All participants were expatriate midwives who were not fluent speaking Arabic but still tried to verbally communicate in Arabic and English:

> *"We communicate according to their (implying Saudi patients)…this language here – Arabic."* (Participant 3)

All participants observed that most of the pregnant women did not speak the English language:

> *"Yes, most of them* (implying Saudi patients) *do not speak English."* (Participant 7)

All participants stated that they didn't know the Arabic language when they first came to Saudi Arabia and this made them feel anxious:

> *"First time I couldn't speak Arabic – it was too difficult and it was most of the patient they will just speak in Arabic."* (Participant 5).

> *"First time when we came here it was all our concern how we're going to communicate with them as we never been in this place before and we find out that also there are some patients that doesn't even know one word of English."* (Participant 2)

One of the participants stated that Arabic was a difficult language, as it was not their first language from their country of origin:

> *"Because really, it is a difficult language and it's not my first language you know…it's difficult to communicate at times with them."* (Participant 3)

When the participants communicated with the pregnant women, the information needed to be understood. The pregnant women needed to decode the message and interpret it, so as to give feedback to the participants. The expatriate midwives could not formulate fully constructed sentences in Arabic, so they used broken Arabic mixed with the English words to try to communicate with the pregnant women:

> *"Uhm, we use broken Arabic in the labour ward, the patients usually communicate in Arabic, in the Arabic language, and we try to communicate to them as much as possible using Arabic language, but we are not fluent in speaking the Arabic; maybe trying to break it up with English and see if they understand."* (Participant 6).

> *"I can communicate with the patient, not very well but still in broken Arabic..."* (Participant 1*)*

The participants tried to speak in a simple Arabic language so that the pregnant women could understand:

> *"…because you try and find out from her what is wrong, where is it, something is happening downstairs. Are you feeling water coming out? You got to try and speak as simple as you can…"* (Participant 7)

Some of the pregnant women could not reply in English as their primary language was Arabic. One of the participants observed that even though they tried to communicate in Arabic, they were not sure if the pregnant women were always interpreting the message from them correctly, as the message needs to be interpreted by the pregnant women so that they could give feedback to the participants regarding their understanding of the message:

> *"…because we try to communicate as best as we can using the Arabic language, but more so often you think that the patient understand us, but you don't know how she's interpreting what we are saying…"* (Participant 6)

Some of the participants also stated there was a small population that did speak English, mostly those who were educated and had been to another country or were younger and it made the communication process easier between the participants and these clients:

> *"…you know some people with the educated person, so like ah can speak English, went to another country."* (Participant 1)

> *"…that's why I'm telling you the younger ones are much better because they can speak English. Like when you are dealing with an English-speaking patient it's good because you will be communicating smoothly."* (Participant 5)

Common Arabic words and phrases were learnt by the expatriate midwives over the months working in the labour ward as the pregnant women's complaints were repetitively related to pregnancy and labour:

> *"We are ok now, because at least the terminology, the one's that we used – basically every day, it's going to be the same questions that you ask from your patients every day."* (Participant 2)

> *"Over the years you pick up on different words that the patients saying and you kind of ask around the same questions to the patients because L&D most of them come with pain, they have the same problems."* (Participant 6)

Some of the participants' used a broken English as English was their second or third language. Some of the participants' first language included Afrikaans, Malay, Tagalog and Malayalam:

> *"So they are the ones teach us. One words by words. That how we learn in the first place."* (Participant 1) [Expressed verbatim as participant stated in broken English.]

One of the participants observed that even though they knew the basic words in Arabic, it became a challenge when the pregnant women had complaints which were not pregnancy-related and the participants had to get a deeper history from the pregnant women:

> *"Except then there is another explanation maybe perhaps that the patient wants to give you, then ah – say for example you see this patient is for a social problem, then it becomes a problem to dig further…because now you have to away from the basic terms that you are using…"* (Participant 2)

Some participants were frustrated that they could not communicate with the pregnant women. One participant even could not sleep as she just wanted to learn the basic terms which caused a psychological imbalance affecting her sleep patterns:

> *"…you cannot sleep you just want to memorise those basic term… you come very frustrated, you come and memorise at least the basics that you can know."* (Participant 2)

All participants expressed the need to give information to the pregnant women explaining procedures, health education and providing support in labour. Participants noted that if they could not speak the same language as the pregnant women in their care, which was Arabic, a lot of important information could be missed, causing added stress to the participants and the pregnant women:

> *"Really want to give health education on how to care about perineal sutures and episiotomies, but due to language you don't even know what is salt."* (Participant 3).

> *"You have to make her understand what is this labour… so each and every time when you are going to do the procedure, then you have to explain*." (Participant 2)

Most participants verbalised that if pregnant women understood them through direct verbal communication, they gain the understanding of the patients. In the absence of verbal communication this presents a challenge for the participants as the care providers:

> *"For me, I think if your patient understands you, you manage her easily…"* (Participant 5)

> *"…even if the patient is not communicating with us at all, it is difficult to provide the care that the patient needs…"* (Participant 6)

One of the participants observed that the expatriate midwives don't understand what some of the pregnant women are saying as the pace, tone and pitch of the Arabic words are different when compared to the other clients, and this impedes their understanding of the message:

> *"And sometimes you don't understand what they are saying because they speak so fast, they will speak the fluent Arabic you don't even understand a word they saying, so it's quite difficult to get information from them."* (Participant 6)

Some participants also observed that if the expatriate midwives could speak the Arabic language, it made the expatriate midwives feel safe and confident in their nursing care, and pregnant women were aware of this:

> *"I feel safe to work, ah, now with my patients and I feel they are also safe, because… they look at you and they will see if you are also ah, you know, anxious and uncomfortable."* (Participant 2)

Participants noted that they did, at times, understand the verbal or non-verbal gestures from the pregnant women; however, they did have difficulty in giving feedback or clarifying the message if it was unclear. They then used the assistance of the doctors who were both Saudi nationals and expatriate Muslims to help with the communication gap as they couldn't speak the Arabic language:

> *"…and the doctors are also available to help us."* (Participant 7)

> *"…normal words the one we always use, they will understand. If like aah they want something else, like we are not used to say in Arabic, yeah, also very difficult, so we need to call a doctor to ask them to explain to a patient what this is all about."* (Participant 1)

However, the doctors were not present all the time in the department, and the participants made use of the senior staff who could understand and speak the Arabic language through years of experience and practice:

> *"Everybody is busy and the doctors you will find they are not here most of the time."* (Participant 3)

> *"…that thing is also like a senior sometimes, they try to interpret for you what the words mean from the patient."* (Participant 1)

By analysing the data, it was evident that verbal communication was important for the expatriate midwives to provide midwifery care to the pregnant women.

4.3.1.2 Sub-theme 2: Non-verbal

Non-verbal communication is an important tool which shows one's attitudes, emotions and true feelings (Segal et al., 2016:2).

It was clear that all participants used non-verbal communication to communicate with the pregnant women, including facial expression, gestures and signs.

> *"Sometimes she will shake her head to say that she understands…"* (Participant 6)

> *"I will communicate with her by talking broken Arabies, then by facial expression – some if I don't know I try to explain something expression or something."* (Participant 4)

The facial expression of the pregnant women was frequently used in communication because the participants could not speak fluent Arabic with the pregnant women. When the pregnant women came to the labour and delivery ward, they were dressed in their cultural clothes, the abaya, hijab and burka, which covered their body and face. They are then taken into a private room during admission to maintain privacy and thus modesty, where these clothes were removed. The participants would conduct a full physical examination in the labour ward where the pregnant women's facial expression could be seen:

> *"… we have to take them in private and only when they unveil their faces, you can see that the patient is crying or she is grimacing with pain or she's holding her abdomen."* (Participant 6).

The pregnant women changed into the hospital labour gown if they were confirmed to be in labour and were taken to the delivery room in preparation for delivery. They remained in the hospital attire until delivery was complete and then they used their cultural attire when they were transferred to the postnatal ward after delivery for post-delivery care. When the participants were able to see the pregnant women's facial expression, they could read their emotions like pain, tension, anxiety, etc. All participants expressed that they used body gestures to communicate with patients as part of the non-verbal communication:

> *"…but maybe by looking at the patient you will also get like data to say that the patient is having certain kinds of symptoms…you know the data that you can see that the patient telling you that she is feeling."* (Participant 6)

> *"…it is mostly expression. They mostly show us "Fi Alam" ["Fi Alam" in Arabic means that they have pain.] They tell you they have pain."* (Participant 7)

The Saudi nationals spoke Arabic to the participants when they came to the labour ward. If the participants could not decode the message and reply to pregnant women, the pregnant women used body gestures to try and make the message clearer. The participants attempted to decode the message back to the pregnant women and reply by using broken Arabic and body gestures. The participants claimed that it was easier to use gestures when their broken Arabic was not clear:

> *"We just use sign language, we have to improvise for the patient's understanding."* (Participant 5)

> *"Sometimes she will shake her head to say that she understands."* (Participant 6)

One of the participants stated that even though she tried to use body gestures to communicate with the pregnant women, she still could not understand what the pregnant women was saying:

> *"You can feel it because whatever she is trying to tell you, you try to reason and then with the sign language – but then still it doesn't make a sentence, it doesn't make a sentence, it doesn't make a, you know – ah, it doesn't make sense at the end of the day."* (Participant 2)

Maternity care is an intervention-based care, as the ultimate goal is having a healthy mother and a healthy baby. Participants noted that extensive communication was needed for care to be rendered to the patients. Therefore, there were a lot of body gestures and tactile communication which is involved even if the Arabic language cannot be spoken properly:

> *"…as you know, maternity – it's mostly about practicalities, like touching and seeing, so communication is a lot of actions."* (Participant 7)

> *"But others will try by all means to use sign language until you understand really what she wants."* (Participant 3)

Non-verbal communication played a vital role in communication in the context of this study, as the expatriate midwives spoke little to no Arabic with the pregnant women.

4.3.2 Theme 2: Communication Challenges

Communication in the maternity setting is unique as midwives play a key role in ensuring pregnant women have a safe birth experience, however, factors like miscommunication, may lead to patient dissatisfaction and poor patient outcomes (Sengane, 2013:321).

The labour and delivery ward provided care to all pregnant women. These women were nursed by expatriate midwives who came from different countries. Communication begins as soon as the patient enters the ward either for assessment or admission if they were in labour (Marshall & Raynor, 2014:328). Participants verbalised there were different challenges to communication that they each experienced which made providing nursing care difficult. The identified sub-themes were the different dialects of Arabic, cultural constraints and lack of patient's birth experiences.

4.3.2.1 Sub-theme 1: Different dialects of Arabic

Arabic is the official language spoken in Saudi Arabia, however, expatriate midwives spoke little to no Arabic with the pregnant women in the labour and delivery ward (Almutairi and McCarthy, 2012:72).

Some participants noted that even though they could speak a little Arabic over some time working in Saudi Arabia, some of the pregnant women spoke different dialects of Arabic, which also caused another layer of complexity to communication between participants and pregnant women:

> *"Certain patients come from the rural area – their Arabic is not the same as patients that will stay in urban areas…"* (Participant 6).

This also caused frustration for some of the participants as pregnant women could not understand them and vice versa. Some participants also noted that even though they became comfortable with certain words and phrases of Arabic, treating the pregnant women who spoke different dialects of Arabic made the communication more difficult:

> *"They speak a different Arabic. The different tribes… It makes it difficult because now we know this Arabic that they teach us, then there's this lady coming from the North and she speaks something different."* (Participant 7)

Participants stated feelings of frustration and disappointment and said that even though they tried their best to communicate with the Saudi pregnant women using broken Arabic and learning a few words and phrases in Arabic, they still could not communicate with certain pregnant women due to the different dialects of Arabic.

It is evident that when pregnant women spoke different dialects of Arabic, understanding the message was unclear and was a challenge for the expatriate midwives.

4.3.2.2 Sub-theme 2: Cultural constraints

Culturally-congruent care is important when nursing patients from different cultures; however, certain cultural traits affect the communication process (Khalaf et al., 2014:13).

The Saudi Arabian women wear an “abaya”, a black, cloak-like long dress and a “tarha”, a headscarf, and a “burka” which covers their face. This caused an initial frustration for the participants as the pregnant women presented to the labour and delivery ward. Participants viewed the Saudi dress code as a challenge as they could not see the pregnant women’s non-verbal cues regarding their symptoms. Participants expressed relief when these clothes were removed:

> *“…because of the culture here there are always covered from head to toe, uhm, so they cannot unveil their faces in front of other people…and only when they unveil their faces you can see that the patient is crying or she is grimacing with pain.”* (Participant 6)

Due to their culture, the pregnant women could not be examined by a male doctor, unless the husband or a female staff member is present. One of the participants stated that they felt pressurised as they have the added responsibility of examining the pregnant women when the pregnant women refused to allow the male doctor to examine them:

> *“…because they* [Saudi patients] *are so concerned about the female doctor and male doctor…They* [Saudi patients] *prefer the female doctor.”* (Participant 1)

> *“Then they don’t want a male, and we don’t have a lot of female doctors. So now the pressure is on you, the midwife. You’ve got to do all the things that the male doctor is supposed to do…”* (Participant 7)

One of the participants stated that the expatriate Muslim midwives understood the pregnant women better due to the similarity of their religion, and therefore, the non-Muslim expatriate midwives asked them for their assistance when the communication between the pregnant women and expatriate midwives was unclear:

> *“…though we are all expatriates, but then now the difference between us as expatriates is – the Muslim midwives – though they are expatriates as well, but they understand it better than us, because then – I think it is the Khoran and the… religion, that’s what*

> *makes them to be… so sometimes you just call them and then you ask 'you understand what this patient is trying to say'…"* (Participant 2)

Some participants observed that the pregnant women preferred to be nursed by the expatriate midwives, rather than their own Saudi nationals. This was due to their culture of respecting one's privacy, as Saudi females are modest and shy in nature:

> *"…there is a cultural problem that sometimes they don't want to have the Saudi's with them in the situation because they don't want them to have the information of them going out…they will even tell you they don't want the Saudi nurses."* (Participant 5)

> *"We notice that they prefer expatriates more than Arab… ah' Arab speaking nurses…I'm sure it's because of the culture and the privacy."* (Participant 3)

Saudi nationals were fluent in speaking the Arabic language as it is their official language of Saudi Arabia:

> *"We have Saudi midwives…because they can explain very well in their own language."* (Participant 1) (Saudi midwives the participants refer to are the Saudi student midwives that were doing the Midwifery training program at the study setting and did their practical training in the labour ward – they were not employed at the study setting.)

One of the participants noted that the communication process runs smoothly with the pregnant women and the Saudi nurse, but the pregnant women preferred the expatriate midwife to deliver her baby, due to the perceived specialised skills of the expatriate nurses:

> *"I watch the Saudi midwife and the South African, or the expatriate midwife, smooth running because she's understanding the Saudi midwife…But for delivery she don't want the Saudi midwife to deliver her, she want the expatriate to deliver her…Ja, I think because of our skills…"* (Participant 7)

Due to the Saudi nationals observing the same cultural practices, the pregnant women sometimes prefer the Saudi nurses and would rather follow the advice of the Saudi nurses, as noted by one of the participants:

> *"…because I've realised like with our students here…you are talking to them, you are encouraging her, and then we will just not understand what is happening with the… when you are like ordering her to push and everything. So at times she won't do what you… start listening to the students."* (Participant 5)

All participants stated that coming to Saudi Arabia was a cultural shock and the added stress of not being able to speak Arabic was definitely a challenge. All participants were expatriates who could not speak the Arabic language fluently. This caused a barrier in the communication process as verbal communication is the most basic way of communicating with people in everyday situations, not only in the hospital setting:

> *"..it is very difficult as expatriates with the language barrier… then with our little broken Arabic we do communicate with them."* (Participant 7)

> *"…language is always a big problem in Saudi because it's not like English, it's not always easy to learn the language…"* (Participant 6)

The data shows that culture plays an important role in the communication process.

4.3.2.3 Sub-theme 3: Lack of patients' birth experiences

All participants verbalised that when patients are inexperienced, they lacked the knowledge and this caused a challenge to communicate with them. Some of the pregnant women are inexperienced about the signs and symptoms of labour, the actual labour process and the procedures that are done in the labour ward. The first-time mothers require lots of knowledge and education as this is a new event in their lives of adjustment:

> *"Especially the little preemies 'cause they're very young also the girls here. And illiterates. They are not educated." (Participant 7)*

> *"You have to make her understand what is this labour, because sometimes the – especially the primigravidas, the ones that delivers for the first time – you understand, some of the things they don't know. So, each and every time when you are going to do the procedure, then you have to explain." (Participant 2)*

Participants need the pregnant women to participate in their own care so that the management becomes easier. When patients understand their diagnosis and treatment, they participate better in their care as they understand why certain procedures are being done, for example, performing a vaginal examination (Hoang, 2008:56):

> *"Like when you are going to do a VE, you tell her to lie on your back and I'm going to check that you're…but you speak in Arabic."* (Participant 5)

> *"Sometimes they will refuse…you try to explain to the patient the reason why you have to palpate…then they will actually work with you."* (Participant 3)

One of the participants stated that the pregnant women became educated as they have access to the internet, and this made the information easier to provide:

> *"It's easy when the patient know…they read from the internet… like now the other one tells me 'I just want to have a natural delivery, no sedation – nothing'."* (Participant 5)

It is important that pregnant women are educated regarding the labour process, so that the communication between the expatriate midwives and pregnant women becomes easier and the pregnant woman can participate in her care.

4.3.3 Theme 3: Communication rationale

Communication is vital for all medical personnel and patients. All participants verbalised that communication was a crucial instrument in providing quality care to patients and their unborn babies.

Participants perceived that by not verbally communicating fluently in Arabic, information was being missed out and there could be miscommunication. They empathised that they could not help the pregnant women even though they had tried their best to communicate with them. All participants used broken Arabic and sign language to best communicate with the pregnant women:

> *"So if there's a break in communication we will not provide that quality patient care – important information can be missed out, so we will not be treating symptoms, we will just be treating on what we're seeing… if we do not understand the patient and the patient does not understand us – care can be mismanaged along the way."* (Participant 6)

> *"…we need outcome of the babies, what is this… very good and the babies must be healthy, the mother is healthy, so that mean we not mismanagement to the patient and baby."* (Participant 1)

4.3.3.1 Sub-theme 1: Gain patients' participation

In order for pregnant women to be managed effectively, pregnant women needed to understand their treatment so that they could participate in their own care (Hoang, 2008:56).

The participants stated as follows:

> *"…primigravidas they come here and doesn't even have a clue what is the process of labour what is going to happen. Sometimes she start being uncooperative."* (Participant 5).

> *"Ja, you can't just say, 'Open your legs, I'm going to do a VE'. No, you have to explain."* (Participant 2)

Most of the participants observed that the primigravidas (patients who are pregnant for the first time), need the correct support, as they have little or no knowledge about the labour process or what to expect. All midwives found difficulty in providing this support where clear communication was a challenge. The patient needed to understand their diagnosis so that they would understand why certain treatment and decisions were being made:

> *"Preemies don't even know what's going to happen to them so they become so uncooperative."* (Participant 7)

> *"Actually we need to explain to the patient what we are going to do with the patient… So as the patient not scared, especially with the first baby."* (Participant 1)

Maternity care involves a lot of procedures. Participants needed to obtain an informed consent from the pregnant women. They needed to inform the pregnant women of the procedure ensuring she understood the information and then getting her permission to conduct the intervention:

> *"…when you are going to do a VE you tell her lie on your back and I'm going to check that you're… but you speak in Arabic."* (Participant 5)

> *"…before we do anything, we explain to her… educating them. Then you telling them what the process is going to be like."* (Participant 7)

Participants noted that if they could speak Arabic, the pregnant women would feel comfortable, be willing to communicate and provide more information, which would have an impact on their care:

> *"…then you try and pacify. Then that girl, 'Oh, this midwife can speak a little Arabic', then she starts opening up and will tell you 'I drank that medicine at home'…"* (Participant 7)

One of the participants observed that even though some of the pregnant women could not communicate with the expatriate midwives, they participated better in their care possibly due to individual factors like personality:

> *"Yeah, all of them are different, you find this one who is… who doesn't speak, but she is very cooperative, and you find this one is just the opposite… depends on her personality."* (Participant 5)

Data shows that support from the expatriate midwives is vital for the pregnant women to participate in her care.

4.3.3.2 Sub-theme 2: Allay patient's anxiety

Anxiety is one of the barriers to communication, which can cause stress and may disrupt normal body function (Marshall & Raynor, 2014:532). All participants felt that if pregnant women understood the communication, they would feel comfortable with their midwife and be confident in her management:

> *"And when they see that you are also cool, you are confident you know what you're doing, then it makes them comfortable."* (Participant 2).

Participants observed that the miscommunication led to even more anxiety as the pregnant women attempted to understand what the participant said. The communication process itself increased the anxiety. Participants were also anxious that if they could not explain procedures in Arabic, the pregnant women would feel uncomfortable:

> *"So now she's anxious, she's scared and I'm telling her do like this and she's not understanding me… It's really difficult."* (Participant 7)

> *"…you have to make the patient comfortable…because sometimes it also disturbs the labour when you see that the patient is anxious…"* (Participant 2)

Some participants also verbalised that if they could speak Arabic, the pregnant women would be more comfortable with them:

> *"…if they see you are relaxed, then they say, 'Sister, you made me feel comfortable because you were just cool…'"* (Participant 2)

Participants observed that pregnant women are generally scared when coming to the hospital, due to fear of previous experiences or fear of the unknown. In order to allay their anxiety, participants have to communicate and educate pregnant women throughout their stay in hospital to try and make them less anxious:

> *"…and all those things we are going to do, VE and all those things. I think they are scared of all those things."* (Participant 3).

Another participant observed that not speaking the Arabic language made the pregnant women feel more anxious and fearful:

> *"I can't speak the language so well, so it becomes difficult when I want to explain to her to turn on to the side cause the CTG now is not good – baby is distressed. How am I gonna say that in Arabic? So now she's anxious, she's scared and I'm telling her to do like this and she's not understanding me…it's really difficult."* (Participant 7)

Some participants noted that if pregnant women do not understand what is going to happen, they become scared and refuse treatment, and this puts the pregnant women and baby at higher risk for labour and birth-related complications like birth asphyxia and even foetal death:

> *"Yes, and also to encounter their anxiety because they come all stressed up… she doesn't even understand what is going on with her."* (Participant 7)

> *" …they refuse everything starting from CTG. Especially with the primigravidas, because they are so scared. They don't know what is going to happen."* (Participant 3)

The participants needed to communicate with the pregnant women in order to provide maternity care. Being unable to communicate made them stressed and frustrated in their jobs of providing care to the pregnant women because they were unsure if they were being understood.

> *"It is important because they have to understand what you really expect from them and what do they expect from us so that the delivery, or whatever is happening with the patient, can run smoothly."* (Participant 3)

> *"Ee.. we don't understand the longer terms. Because she will continue speaking Arabic, thinking we're understanding and the rest we don't understand."* (Participant 5)

Good communication techniques can allay the pregnant women's anxiety and grant the pregnant women a positive birth experience.

4.3.3.3 Sub-theme 3: Increase patient's trust

In order for pregnant women to have a safe labour, there should be caring and loving people around her that will make her comfortable (Karlstrom et al., 2015:4).

Participants stated that for maternity care to be effective, pregnant women need to trust the midwives. They also experienced that when there is no trust from the pregnant women, there is no participation in her care and little confidence in the midwife:

"Then let her ask some questions that she can ask, just to bring trust." (Participant 2)

"And trust. You build that relationship and their trust because you're spending that whole day with her because she's in labour and she is going to deliver." (Participant 7)

"…if you can speak little bit Arabic, they said they are more comfortable with you… they can express themselves, they can tell you a lot of stories actually." (Participant 1)

Participants observed that communication is important as it creates an environment that is conducive for the pregnant women, the midwife and the unborn baby:

"You have to gain the trust of the patient and then you have to make patient comfortable so that the labour – because sometimes it also disturbs the labour when you see the patient is anxious – so communication is very important in the sense that it has to create the environment conducive for you, and for this unborn baby that is coming." (Participant 2)

"You understand, because now if the patient doesn't trust you… you're not creating an environment that is conducive between you, that trust, then that's time you… something might happen." (Participant 2)

Some participants also felt that if pregnant women trusted the midwife during previous deliveries and they were happy and comfortable with that midwife, they will request that certain midwife to deliver her in her next pregnancy:

"…she'll point and say, 'I want (Mary, Mary) has been delivering my babies' and (Mary) and her build a relationship – so that is something good, really good"* (*name changed to maintain privacy of the participant.) (Participant 7)

"Yah, patient will say, yah…'I want you'. Patients sometimes say aah, 'What is your name?' They asking your name and then asking when is your next shift 'so I wanted to come and deliver with you because you can speak Arabic', or something like that." (Participant 1)

Some pregnant women even preferred a certain nationality as they have developed trust in those midwives:

"Sometimes they tell, 'I don't want the South African nurses I want the Malaysian'." (Participant 5).

All participants noted that they spend an increased amount of time with the pregnant women, and this helps them to develop a good nurse/patient relationship. Participants verbalised that if they could speak the language of their pregnant women, which was Arabic, their bond will be much stronger and the pregnant women could trust them more:

> *"If you don't know how to talk you're not building that trust with her and that's a relationship with her that by the time she delivers you can have that trust and connection with her, you know?"* (Participant 7)

> *"…whoever knows Arabic. Ah speak… politely to them…they ask, I want you…"* (Participant 1)

Participants noted that communication was necessary to create rapport with the pregnant women and to make them feel comfortable with the midwife:

> *"… to create the rapport and the nurse-patient-relationship because uhm, as a midwife, you have to gain the trust of the patient and then you have to make patient comfortable."* (Participant 2).

> *"We need to speak in Arabic… give her support – moral support…"* (Participant 1)

They also observed that if the patients are not comfortable with the midwife, they become anxious as they have no trust in the midwife:

> *"So that one – is, why we need Arabic, because to make a patient more comfortable with you."* (Participant 1)

It is evident that when the pregnant woman trusts the expatriate midwife, they will participate in their care.

4.3.3.4 Sub-theme 4: To provide education

All participants said that they needed to educate pregnant women as most pregnant women that came to the labour ward, especially the primigravidas, didn't have the experience on the process of labour and what to expect:

> *"Like even antenatal, you find out these primigravidas, they come here and doesn't have a clue what is the process of labour, what is going to happen."* (Participant 5)

> *"Mostly the primigravidas are the one who are giving us problem, with the multigravidas they know exactly what's happening."* (Participant 3)

All pregnant women are closely monitored as each participant cares for one woman at a time, which facilitates an increased amount of time for communication. If pregnant women are uneducated, the participant needed a large vocabulary of words and phrases to effectively communicate with the pregnant women. Participants need to keep the pregnant women informed at all times:

> *"So, they are very scared. So, we need to explain what we are going to do, what procedure we need to do."* (Participant 1)

> *"Isn't it we have to explain the procedure to the patient… she must understand what you are doing to her. You cannot work without telling her what you are going to do to her."* (Participant 5)

All participants agreed that every procedure and management needed to be explained to all pregnant women:

> *"And then you also tell her, 'You know your cervix is open like this, then it means that labour is just starting' or 'You might have contraction pains, but this is not the real contractions.' You understand?"* (Participant 2)

> *"During labour we are communicating again – we have to teach her about how to – how she will tolerate the pain, we are giving the injection that time we are – and we giving analgesics also we have to explain…"* (Participant 4)

Some participants observed that it was a challenge to communicate in Arabic, as they couldn't speak Arabic fluently:

> *"Others will understand when you say you must at least use water and salt and those, but others won't understand. They don't even know what is salt."* (Participant 3).

> *"The process of labour so you need to explain especially when we, ah, did examination. So she is, like ah, she's still in early labour, we need to explain to them. So what is this labour pain, how is feel of the labour pain."* (Participant 1)

Participants also stated that even though they needed to explain procedures and educate the pregnant women, they also needed to get obstetric history and establish the reason for presenting at the hospital and this was difficult as they could not communicate well in Arabic:

> *"Maybe sometimes we have – when we will ask family history or her history we have some problem with that. This is – we are not able to understand… aah, sometimes we*

are forgetting like history hypothyroidism… maybe she will not understand that." (Participant 4)

"… the basic questions we do ask the patient is: 'Why is she coming to the hospital, what is her main complaints, when did the symptoms start, is she feeling the baby moving… but if she cannot give us that information… so how do we know?" (Participant 6)

Participants stated that educating the pregnant women was important, but it was not easy to communicate in Arabic:

"Because with an episiotomy you don't know how to take care of it. You just try to explain to her sit on it, just walk properly, don't…mmm, we do try but it is not easy." (Participant 5)

One of the participants noted that the communication challenges could lead to medical legal hazards because whatever procedure is performed, it needs to be documented, including communication:

"Yeah, because being in Saudi Arabia, there is so much legalities that concern, there is so much of medical legal hazards that can happen that as far as documentation is concerned, because everything we do we have to document, even if we communicate to the patient, like health education, we have to document." (Participant 6)

It was strongly sensed that participants were eager to educate the pregnant women, but felt hopeless due to the language barrier.

"But we try our best to communicate with them as much as they can understand us." (Participant 6)

"Mmm… but isn't now because of the language we can't provide best unless she ask and then we try to explain… it's not easy to educate them because of this language." (Participant 5)

Education was necessary to keep the pregnant women informed so that the pregnant women could participate in her care.

4.3.4 Theme 4: Communication Solutions

All participants shared common feelings regarding the solutions to overcome the communication challenges that they experienced in the labour ward. Most participants

perceived that the solutions to communication challenges were to employ interpreters, have English/Arabic classes, provide patient education in antenatal classes and provide communication resources or material. They verbalised that it was the decision of the organisation to assist in promoting these solutions to help them so that they can deliver effective quality maternity care.

4.3.4.1 Sub-theme 1: Employ interpreters

All participants shared mutual feelings of not being fluent in the Arabic language. They strongly perceived that the organisation should provide interpreters to assist with the communication challenges that they experienced as presently they do not have interpreters working in the labour ward:

> *"For me, I feel each unit should have an interpreter that should assist the expats."* (Participant 6).

> *"We could be given interpreters on every shift. It will help."* (Participant 7)

Most participants communicated that these interpreters should work both day and night shifts so that the midwives can be assisted 24 hours:

> *"… just have interpreters… twenty-four hours, we use interpreters twenty-four hours."* (Participant 2)

> *"If we can have an interpreter that is just allocated in this department and stay with us all the time."* (Participant 3)

Participant 2 noted that by having interpreters, it would prevent miscommunication between the expatriate midwives and the pregnant women:

> *"So just have interpreters, so as to care any miscommunication and all those things."* (Participant 2)

Another participant stated that the interpreters would be able to give information to the pregnant women:

> *"At least he or she can be able to explain to them what is really needed from them."* (Participant 3)

One of the participants noted that even though the interpreters would help to bridge the communication gap, she also shared feelings that the pregnant women would trust the

interpreters more than the midwife as they can speak Arabic, and this may cause problems in their care:

> *"And other patients they will maybe trust the interpreter and not the nurse."* (Participant 5).

Some participants also shared feelings that interpreters should be available in the antenatal clinic to educate patients:

> *"…interpreter to come and be helping us interpreting, educating them in MCH."* (Participant 7)

> *"Education antenatal; there I think that is where the interpreter is needed the most."* (Participant 5)

According to one of the participants, it was noted that even if the interpreters were available, the expatriate nurses will still learn the Arabic language, as the interpreters could not assist all the pregnant women at the same time, the nurses will eventually learn the Arabic language:

> *"I think they will learn… the translator is gonna translate in English for her so the nurse can put the English and Arabic together and obviously she will understand it and probably try and practice it… The translator can't be at each patient at the same time so the nurse has to communicate with the patient on a one-to-one, irrespective if the interpreter is there or not."* (Participant 6)

One participant verbalised that the interpreters could assist with the communication gap when the pregnant women's husbands spoke a different dialect of Arabic:

> *"Even with the husbands. The husbands will come and ask us questions, and some of them have this deep Arabic and you don't understand them."* (Participant 7)

Participants noted that having interpreters to bridge the communication gap will make the midwifery care more effective.

4.3.4.2 Sub-theme 2: Arabic/English classes

All participants shared mutual feelings that the organisation should provide English/Arabic classes to all new employees arriving to work in the hospital for the first time. They noted that if they knew some of the Arabic language, this would help them when they go to the wards and they won't be afraid to try to communicate with the pregnant women:

> *"I feel that the hospital should provide, like, basic lessons on orientation for new employees, uhm, English-Arabic lesson, especially like with basic Arabic so, when the nurses go back to the unit they can actually practice and learn to communicate…"* (Participant 6)

> *"We find that one of our difficulties and that's why I would recommend that really we have Arabic classes when we do our orientation. Especially for the new staff."* (Participant 7)

One of the participants also stated that, even though the Arabic classes would be beneficial, it would not be easy to grasp all of the Arabic words in one or two days:

> *"The first thing I think especially for expatriate you need to sit in Arabic class… But it's not easy when you sit for one day or two day you will get all the Arabic word. Is not easy."* (Participant 1)

However, one of the senior participants verbalised that the organisation did offer Arabic classes in the past, however they were charging a fee, and employees did not attend as they chose not to pay:

> *"Before they had people but they charged. So people were not interested because of the charge… so no one was interested to pay."* (Participant 5)

One of the participants also noted that there should be peer-to-peer teaching of Arabic in the labour ward. She verbalised that the nurses can teach each other on a social basis so that they can become familiar with the common words and phrases:

> *"Let's teach each other, have that one or two social time where we are teaching each other the different words because every day you learning a different word… we are all get that information. It's interesting."* (Participant 7)

All participants agreed that attending Arabic/English classes would mend the communication gap between the pregnant women and the expatriate midwives.

4.3.4.3 Sub-theme 3: Provide patient education in antenatal

All participants shared mutual feelings that pregnant women coming to the labour ward were not educated in the antenatal clinic, i.e. Maternity/Child Health Clinic (MCH). They verbalised that if they were educated in MCH, then they would be knowledgeable and they could understand their treatment and they could cooperate better:

> *"Education antenatal… Even in antenatal they don't discuss the process of labour…then they will come knowing what is going to happen."* (Participant 5).

> *"…what is expected during labour – it needs to be proper education during antenatal visits."* (Participant 2)

One participant noted that the pregnant woman cannot absorb the education in the labour ward as she has pain and she cannot concentrate, therefore the education will be more effective in the antenatal:

> *"… be proper education during antenatal visits… Because sometimes, no matter how much you want to explain what to the patient, that time the patient's got pain… she cannot concentrate."* (Participant 2)

Some participants also shared feelings that if the pregnant women are educated in the antenatal, they would be prepared when they come to the labour and delivery ward and this will also alleviate their anxiety:

> *"I think antenatally they can be educated in the clinic and told what is going to really going to happen when you are in the delivery room… that thing will also alleviate their anxiety."* (Participant 3)

> *"If she's attended the clinic, she's been in communication with the doctors. She's more relaxed, she's not so anxious…"* (Participant 7)

Another participant also suggested home nursing. She stated that nurses should go to the pregnant women's homes and assess the woman, her environment and give health education. She noted that this will make the pregnant woman more educated and relaxed when she comes to the labour and delivery ward in the hospital and this will help the midwives become familiar with the Arabic language:

> *"Also with communication, we should have home nursing. Before and even go to the homes and educate and see the environment that she's coming from, and also teach her just the basic things for personal hygiene… it will help because now she will be used, she'll also be educated, she will be more relaxed… now we will also be exposed and will be able to start speaking the language more."* (Participant 7)

One of the participants stated that pregnant woman could be educated in antenatal, and they could visit the labour and delivery ward to see how care is provided, as this might alleviate their anxiety:

> *"Yes, for a visit and see what is really happening. There is a first stage, then after the first stage you'll be this thing and then they see the delivery room and that thing will also alleviate their anxiety."* (Participant 3)

According to one of the participants, she observed that even though the Saudi patients attended the antenatal clinic, they were not educated properly as there are a huge number of expatriate nurses that work there and the language barrier was a problem:

> *"Most of them… they do attend clinics… maybe even there antenatally…. because even there in the clinics is mostly expatriates….s till trying to explain to them but the language is the problem."* (Participant 3)

It is, therefore, evident that education to the pregnant women in the antenatal phase of pregnancy is important so that the pregnant women can make decisions about her care.

4.3.4.4 Sub-theme 4: Provide communication resources

Participants observed that if they had resources to assist with the communication barrier, this would help them immensely. Participants verbalised that they could not communicate fluently in the Arabic language with the Saudi pregnant women, therefore they needed assistance with resources to communicate with the pregnant women.

Some participants verbalised that having computers with pictures in the labour ward would assist them in providing education to the pregnant women. These pictures could represent the signs and symptoms of labour, like a picture of water running down the patient's legs could represent that her amniotic sac has ruptured. These pictures could be translated in Arabic and shown on the computer screen so that the pregnant woman understands:

> *"… and another thing that would help in L and D is to have the computers where there will be an education – the pictures… Translated in Arabic, what do I mean when I say she's not in labour."* (Participant 2)

> *"We really need some sign languages, so if we do that placards, those little pictures… really will help…"* (Participant 7)

One of the participants had a previous experience of working in Saudi Arabia, where the expatriate midwives would educate the pregnant women in the antenatal clinic by showing them pictures. They would take them to view the labour and delivery ward, as this made them familiar with the surroundings of the labour and delivery ward and they would be familiar with expatriate midwives whenever they would be admitted:

> *"Previous hospital… so an hour every morning where we are showing them pictures and we're showing them what happens in the labour room, even giving them little visitation rounds in the labour room. They can be getting familiar with the faces…"* (Participant 7)

Some participants noted that having a dictionary in Arabic/English, with common words and phrases used in the labour and delivery ward, would help. They felt this could be a good resource as they could refer to this dictionary when they are having communication difficulties:

> *"They need to give us the – like dictionary – for us, so what to ask, so the question, what they are expecting them to answer back… so what they will answer, the same question, the same answer."* (Participant 1)

Another participant verbalised that having pamphlets or little cards with pictures will also help them to communicate with the pregnant women. These pamphlets and cards should be in Arabic and English, so that the pregnant woman understands:

> *"… we will have little pamphlets or I think little cards, you know the card system? We will show something like water."* (Participant 7)

Another participant stated that deaf and dumb mothers were isolated even if gestures were used to communicate and therefore, the use of pictures or placards will help with those patients:

> *"Even if she shows signs… you know sometimes we have a deaf and dumb mother… we've had one or two so if we do those little pictures, it will really help with the deaf and dumb mother."* (Participant 7)

Another participant suggested having books translated into Arabic and English that would have information about the pregnancy and labour and this can be used as a resource to bridge the communication gap:

> *"We can… if they want, can provide some books also."* (Participant 4)

Participants noted that if there was this two-way communication between pregnant women and expatriate midwives using the resources, the midwives could also learn the Arabic from the pregnant women:

> *"Maybe a picture card, a picture, I was going to introduce… the patient, so they can confirm 'This is what I am talking about.' 'What is this in Arabic?' So she is also teaching me."* (Participant 7)

However, one of the participants stated that not all Saudi nationals can read Arabic, which poses a dilemma when communication resources will be used:

> *"I'll say maybe 5% that when you are – how you know that they don't understand also Arabic is when you are asking the patient to sign then she will say 'I cannot sign', then we have to get the thumb print instead… So, that one I know that she doesn't understand… and she cannot even read her own language – Arabic."* (Participant 2)

4.4 Summary

In this chapter the findings of the research study were presented. Four themes emerged, namely communication methods, communication challenges, communication rationale, and communication solutions. An in-depth discussion of the themes was carried out. In the chapter that follows the discussion of the findings are presented as it relates to the current available literature.

CHAPTER 5: DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The chapters that preceded the current chapter provided a foundation for the study and a literature review that explored the role of communication in providing quality maternity care by expatriate midwives in a military hospital in Saudi Arabia. Thereafter the research methodology and the findings were described. Four themes emerged from the research data, which were as follows: communication methods; communication challenges; communication rationale; and communication solutions. This chapter provides a discussion of the findings, recommendations and the final conclusion.

5.2 Discussion

The aim of the study was to explore and describe the communication experiences of expatriate midwives while caring for pregnant women in the labour and delivery ward of a military hospital in Saudi Arabia. The descriptive qualitative approach used in the study is appropriate as the current practice of the communication in the labour and delivery ward remains a challenge for the participants (Grove et al., 2013:217). The researcher describes the communication experience as they are subjectively experienced by each participant.

5.2.1 Objective 1: Describe the communication of expatriate midwives while caring for pregnant women in the labour and delivery ward of a military hospital in Saudi Arabia

The midwife is a key component in the labour process as she provides support and assists the pregnant women safely through childbirth (Marshall & Raynor, 2014:328). To fulfil this role, communication should be effective to promote a positive relationship between the pregnant women and the midwife (Marshall & Raynor, 2014:184).

In a study conducted by Van Rooyen et al. (2010:1-9), the reflections of the South African nurses' experiences about working in Saudi Arabia were identified. The study was conducted at a hospital in Saudi Arabia which had a workforce from 31 different countries. The study setting did not specifically mention the name of the departments that the participants worked in the hospital, however, a sample size of eleven South African

participants who worked in various departments of the hospital were interviewed. It was noted that participants were faced with the challenge of communicating with patients and their family members who could not speak English. They felt that although they were able to learn a few Arabic words, it was usually not enough to communicate effectively.

Participants in that study also felt that when it came to non-verbal communication, they were at a disadvantage as it was the cultural practice of women to cover their head, face and body. They felt that communication was compromised as they could not observe the female patient's emotions, nor observe the patient's head. This impacted their care as a relationship between a nurse and a patient is a therapeutic alliance that can be used to offer information, reassurance and warmth (Van Rooyen, 2010:7). It was difficult to establish a relationship if the nurse could not communicate directly with a client. In the present study, participants shared mutual feelings regarding the language barrier as they also could not communicate fluently in Arabic with the pregnant women.

The participants also found difficulty in observing the pregnant women's non-verbal gestures due to their cultural attire and these factors affected the communication in the labour ward; however, wearing the hospital attire during labour did assist with observing their facial expression. The benefit of the hospital attire also alleviated the communication difficulty during admission to the labour and delivery ward and during the conducting the delivery in stage 2 of the labour process.

One of the participants in the present study verbalised that the pregnant woman will nod their heads to acknowledge the information that was received from the expatriate midwife, however, she was unsure if the pregnant women interpreted the message correctly due to the language barrier.

Pregnant women in the current study present to the labour ward with common signs and symptoms, one of which is abdominal pain. Abdominal pain is a symptom that is subjective and objective.

In the Saudi setting, the female patients are dressed in their Saudi cultural attire that covers their body and face. Participants in the present study felt helpless as they were unable to see their facial and body gestures regarding their symptoms of, for example, pain. Participants felt it was a challenge as they were unable to speak to the patient in Arabic, and now they couldn't even observe their facial and body gestures. Participants had the same mutual feelings of not being able to communicate effectively although they learnt a few Arabic words. The participants in the present study also experienced the same communication barrier to the

women covering their heads and not being able to see their non-verbal cues, prior to admission and after delivery when hospital attire were no longer being worn.

Similarly, Higginbottom et al. (2014:297-304) studied the communication challenges facing immigrant women in rural Alberta. A total of 31 people participating in the study were healthcare workers who spoke different languages, amongst which were Arabic, Urdu, Tagalog/Filipino, French, Swahili, Hassaniya and Tigre. The national languages in Alberta were English and French. Participants in that study found challenges in verbal communication due to the language barrier, there was miscommunication, lack of trust in healthcare workers and cultural implications.

In the present study, participants also experienced the communication challenges with the pregnant women due to the language barrier of not being able to speak Arabic fluently. Participants in the present study also experienced lack of trust from the pregnant women as they could not speak Arabic. There were cultural constraints identified by the participants during the midwifery care rendered by the expatriate midwives.

In a study done by Almutairi (2015:16-23), studying registered nurses' experience in Saudi Arabia, participants felt their ability to communicate in Arabic was either limited or absent. This study was conducted in an 800-bedded hospital in Saudi Arabia, in which 24 multicultural nurses were interviewed. The participants were all expatriates and outlined their cultural competence of nursing Saudi patients. They worked in the medical, surgical, paediatric and gynaecology wards, which were acute care areas. They discussed how they tried to communicate with the Saudi patients using body language and other common body gestures. They also used the assistance of colleagues, patients' family and relatives to aid with the communication barrier.

Similarly, in the present study participants had the same mutual feeling where they could not communicate in Arabic with the pregnant women. All participants in the present study stated that they use non-verbal communication, including body language and body gestures. Participants also stated that they had no interpreters at the facility where the study was conducted; therefore the expatriate midwives used the assistance of their senior colleagues or doctors who spoke Arabic, to help with the communication barrier.

Almutairi (2015:425-431) researched the cultural and language differences as a barrier to providing quality care in Saudi Arabia. Almutairi conducted a systematic review, which showed that language was a barrier when giving information to Saudi patients and when the language is not clear, effective communication is a challenge. He also suggested that the need to

improve the communication between patient and healthcare workers was essential to attain high quality and safe care. All participants in the present study expressed their challenge of not speaking the Arabic language fluently. They could not get history from the pregnant women or explain procedures due to the language barrier. Some participants were also concerned that they could not communicate in emergency situations where the baby or mother was compromised. Some participants also felt that the communication barrier could lead to miscommunication and mismanaged care for both mother and unborn baby.

In a study done in the United Kingdom by Williams, Morris, Stevens, Gessier, Cella & Baxter, (2012:86-93), midwives were researched in how they estimate labour pain. Midwives observed patients for pain from the doorway of the labour room. They did not routinely ask the patients for their pain ratings. The study shows that verbally asking a patient for her pain rating is better than estimating it.

In the present study, participants relied heavily on the non-verbal cues when patients came into the labour and delivery ward. Due to their cultural dressing of wearing a hijab and burka (covering of the head and face), facial expressions could not be seen on admission and pain was one of the factors that could be mismanaged. The pregnant women, in the present study, did remove their cultural attire when they were admitted to the labour and delivery ward and were dressed in the labour and delivery ward gown for their duration of their stay in the labour and delivery ward. Participants did mention that, even though they couldn't see the pregnant women's facial expressions, they could see their body gestures where the pregnant women held their abdomen if they had abdominal pain. This alerted the expatriate midwives to subjectively diagnose the patient's symptom of pain.

In the present study, participants could not verbally ask the Saudi patients for their pain rating as proven in the above study to be most effective by Williams et al. (2012:86-93), as the expatriate midwives could not speak in Arabic. Using a pain scale rating was available, but not effective for verbal use between the pregnant women and the expatriate midwife due to the language barrier.

The basic medium for providing quality healthcare is communication, which is a key factor to patient satisfaction (Armstrong et al., 2013:262). Language is used worldwide as a means of communication. The language barrier poses a potential harm if patients do not understand the healthcare provider. In a study done by Al-Harasis (2013:1- 7), he researched the impact of language barrier on nursing care in Saudi Arabia. The study showed that nurses found difficulty in dealing with Arabic speaking patients and most of the patients found difficulties in communication with non-Arabic speaking nurses and patient satisfaction were affected.

In another study done by Halligan (2005:1565-1572) in which critical care nurses' experiences were investigated in caring for Islamic patients in Saudi Arabia, nurses found communication was difficult due to the language barrier and this caused tension between the patient, family and nurse. The present study shows that participants also saw the same fear of miscommunication and the reality of mismanagement. The participants also identified the anxiety of the pregnant women when communication did not flow smoothly.

5.2.2 Objective 2: Explore the communication experiences of the expatriate midwives while caring for the pregnant women in the labour and delivery ward of a military hospital in Saudi Arabia

The expatriate midwives have diverse roles in which they have to be a caring supporter, advocate, skilled practitioner, vigilant observer and an accurate record keeper (Marshall & Raynor, 2014:328). Hence, communication between the pregnant women and expatriate midwives is vitally important to carry out these functions.

When communicating with Arabic patients, it is necessary to understand the significant differences between Arabic and other languages (Van Rooyen, 2010:6). In an article written by Lamadah and Sayed (2014:20-25) that discussed the challenges facing the nursing profession in Saudi Arabia, it was noted that communication is an important component in the provision of nursing care. It was also noted that many expatriate nurses are not competent in the Arabic language. Communicating in the Arabic language increased patient satisfaction and improved the outcome of nursing care.

Khalaf et.al. (2014:13-29) examined the nurses' views and experiences of caring for malnourished patients in Saudi Arabia, participants felt there were misunderstandings and miscommunication due to the language barrier. The researchers in that study felt that it was important to educate expatriate nurses about language.

In the present study, all participants felt it was a challenge to communicate with pregnant women as they were not fluent in the Arabic language. Some participants stated that it was not their first language from their country of origin and it was a difficult language to learn. Some participants who have been working in Saudi Arabia for a few years said that, even though they could speak the Arabic language, they still were not fluent, and they still needed assistance when they could not understand the patients. They sought the assistance of their peers or doctors when they needed help to communicate in Arabic.

Rowe et al. (2002:63-83), investigated communication between health professionals and women in maternity care. It was stated that clear and readily available information is important

to women and that women need staff to listen to them and respond to their individual needs. Interventions that promoted different styles of communication and involving patients in their decision-making increased the success of their care.

In the present study setting, women are nursed on a one-to-one nurse/patient ratio in the labour and delivery ward. Participants felt that they tried their best to educate pregnant women in Arabic and involve them in their care, but this was a huge challenge due to the language barrier. Participants in this study had to use the assistance of senior midwives and doctors to help with the language barrier.

A phenomenological study by Halligan (2006:1565-1573), examined the critical care nurses' experience in Saudi Arabia when caring for patients of Islamic faith. It was found that communication was primarily non-verbal and caring was viewed as "being more difficult due to the language barrier". He also stated that tension was created between the patients and the families often attempted to get the attention of the staff by using a number of gestures, such as, 'clicking of fingers', which was considered aggressive by the participants who came from the Western culture. Participants in that study felt feelings of mistrust, as there was a lot of miscommunication.

In the present study, participants also used non-verbal communication to communicate with the pregnant women. They also expressed the same feelings of heartache and despair of the language barrier in providing care. Participants also stated feelings of mistrust. In the current study, participants felt that being unable to speak the same language as the pregnant women, the pregnant women would have no confidence and trust in the midwife, and therefore, they would not cooperate with the midwife. This could negatively affect the patient outcome in providing care to the Saudi pregnant women. However, some participants in the current study also noted that certain pregnant women would request the names of the expatriate midwives who delivered their babies previously, due to their specialised skills and a positive labour experience that was provided by the expatriate midwives.

Van Rooyen (2010:1-9) investigated the experiences of South African nurses in Saudi Arabia, communication barriers identified by the participants were language differences and accents. The participants stated that not understanding what the person was asking or saying affected their feelings of self-belief, self-worth and their morale. They experienced feelings of helplessness, frustration and stupidity and described these experiences as very painful.

Similarly, participants in the present study expressed mutual feelings. They felt helpless as they could not understand the pregnant women. They became frustrated trying to use broken

Arabic and English trying to communicate with these pregnant women. One of the participants even had sleepless nights trying to remember the Arabic words just to communicate with the pregnant women. Some participants also stated that even though they could communicate a little in Arabic, certain pregnant women came from different areas of Saudi Arabia, therefore their dialects of Arabic were different. This also caused a challenge for the expatriate midwives to understand certain pregnant women.

Higginbottom et al. (2014: 297-304) investigated communication challenges in maternity care for immigrant women in rural Alberta, it was found that having bilingual interpreters showed concerns related to confidentiality and trustworthiness. People who come from the same place know each other and this jeopardises the confidentiality of information between the pregnant women and her nurse or physician.

In the present study, there were no qualified Saudi midwives employed at the time of the study. However, there were Saudi midwives that were being trained at the time of data collection, but they were only a few, having trained Saudi midwives will be a long-term solution. Participants expressed that if they could speak the Arabic language, providing nursing care would be easier and will run smoothly. The majority of the participants felt unhappy about not having Saudi nurses employed in the ward, which could help with the communication barrier. However, some participants also felt that the pregnant women may feel uncomfortable exposing themselves during procedures in the presence of the Saudi nurses, due to the cultural factors.

Culture plays a key role in providing maternity care. A study conducted by Karout et al. (2013:172-182) explored the cultural diversity of Saudi women's experience of maternal health services. It was highlighted that Saudi women preferred to be with a female rather than a male caregiver during birth or during any other gynaecological assessment, due to religious and cultural issues. Similarly, in the present study, when Saudi patients refused to be examined by a male doctor, participants found it difficult to explain to the patient that a female doctor was unavailable, due to the language barrier. Participants felt helpless if the patients could not understand and they felt they were not respecting their culture, when in fact, not having a female doctor on duty was an administrative issue.

A study was also conducted by Nailon (2006:119-128) who studied the nurses' concerns and practices with using interpreters in the care of Latino patients in the emergency department. Participants in that study felt that lack of interpreters impaired the nurses' abilities to gather valuable and applicable clinical and cultural information. These interpreters should be provided with training and support to deal with difficult patients.

In an article written by Albougami in 2015 (166-172), he suggested that interpreters are needed to facilitate communication between English-speaking staff and Arabic-speaking patients. He also suggested selecting an interpreter of the patient's gender is likely to result in a more comfortable and efficient interpretation process in consideration of religion and culture. This is further enhanced by a study done by Higginbottom et al. (2013:12-14) where intercultural communication between nurses and Moroccan patients in Spain were examined. Participants preferred interpreters to make sure treatments were being followed and to gain patients' cooperation.

In the study done by Hoang in Australia which was previously mentioned (2008:55-61) where language and cultural barriers were examined of Asian migrants, it was found that having trained interpreters could assist with the language problems. Likewise in the present study, all participants expressed the need for the organisation to employ interpreters that would work in the ward on a 24-hour basis, both day and night shifts. They felt that this would help to bridge the communication barrier between the expatriate midwives and the pregnant women.

In a study done by Montie, Galinato, Patak and Titler (2016:65-72), in which Spanish-speaking patients were investigated regarding the call light use, Spanish-speaking patients viewed that interpreters negatively impacted their care as they felt that the interpreters were unable to speak the same type of Spanish as the patients. Spanish-speaking patients used the assistance of English-speaking family members and friends.

In the present study, one participant also verbalised the negative impacts of having interpreters as she felt that the pregnant women would trust the interpreter more than the expatriate midwife and the interpreter may communicate the wrong information. Expatriate midwives do not speak Arabic, and the information being translated to the patient by the Saudi nurse may be miscommunicated

Alharasis (2013: 1-7) studied the impact of the language barrier on quality of nursing care at a hospital in Saudi Arabia. It was found that nurses preferred attending an Arabic course during the orientation period before starting work. They also preferred to use a common words dictionary as a solution to the language barrier.

Similarly, in the present study, all participants felt the need to attend Arabic/English classes which should be provided by the hospital. Most participants also felt the need to have resources like a dictionary or pamphlet with common words and phrases to use in the labour and delivery ward to assist with the Arabic language with the pregnant women.

Hoang (2008:55-61) investigated the language barriers of Asian patients in Australia. It was found that antenatal education programmes were conducted in English without an interpreter. Patients expressed the importance of attending these programmes, but due to the language barrier, Asian women avoided these classes.

In the present study, all participants expressed the importance of educating Saudi patients in MCH (maternity/child health clinic), so that when patients arrive at the labour ward, they are informed on what to expect. Some participants also felt the need for interpreters to be available in MCH to educate these patients in Arabic so that they could understand.

Communication in the labour and delivery ward plays an important role as midwifery care is provided to the pregnant women and the unborn babies. To prevent a negative birth experience for the pregnant women, communication needs to be clear and understandable. Different communication solutions were identified that may bridge this communication gap.

5.3 Limitations of the study

The study was conducted at one of the Saudi Arabian military hospitals situated in the eastern region of Saudi Arabia. The study was only conducted at the labour and delivery ward of the hospital and other departments were not included. The sample size was small and limited to only one hospital.

5.4 Conclusions

Communication is a unique process in the maternity setting between the pregnant women and the expatriate midwives. The expatriate midwife promotes a positive birth experience for the pregnant woman and the unborn baby by ensuring the pregnant women's physical and emotional needs are met.

The research question that guided the study was: What are the communication experiences between expatriate midwives and pregnant women in the labour and delivery ward of a military hospital of Saudi Arabia? From the findings, one can conclude that communication by expatriate midwives with pregnant women is a challenge faced daily in the labour and delivery ward. Expatriate midwives attempt to use different communication styles and seek resources to help overcome this challenge.

Feelings of helplessness, despair, low self-esteem and trust were common emotions experienced by the expatriate midwives due to the communication difficulties with the pregnant women. Participants felt that if they were fluent in the Arabic language, they could provide quality care and communication would be effective. They would also feel confident in their management and would feel safe to practice. Expatriate midwives felt that if they spoke the

same language as the pregnant women, the pregnant women would cooperate better and would understand their condition better. They would even cooperate during procedures and midwives would be confident in educating the pregnant women better.

Expatriate midwives felt the need to have interpreters employed at the ward on a full- time basis, so that they could assist with the communication barrier. All participants felt the need for pregnant women to be educated in the antenatal clinics which will make them knowledgeable when they come to the labour and delivery ward. They also felt that having Arabic/English classes when they first come to Saudi Arabia would make them more comfortable before they go to the ward.

In Chapter 1, the researcher noted that expatriate midwives provide specialised care to pregnant women and their unborn babies. These expatriate midwives who worked in the labour and delivery ward in a hospital in Saudi Arabia came from different countries. Expatriate midwives spoke English whereas the pregnant women spoke Arabic. Communication starts when the pregnant women enters the labour and delivery ward and the expatriate midwife needs to plan the pregnant women's care based on her physical and emotional needs. The study findings show that even though there were the identified communication challenges in the labour and delivery ward, expatriate midwives used their own unique communication styles to communicate with the pregnant women and provide care. However, these challenges are faced on a daily basis as no Saudi midwives or interpreters worked in the labour and delivery ward.

5.5 Recommendations

Recommendations that follow are based on the scientific data generated by the study and literature review conducted during the study. The findings indicate that expatriate midwives experience communication challenges that can hinder a positive birth experience for the pregnant women. Good communication is key to building trust relationships between the expatriate midwives and the pregnant women to ensure the goal of a safe labour is achieved.

5.5.1 Employ interpreters

Expatriate midwives working in Saudi Arabia come from different countries where Arabic is not their first language. Several studies have shown the positive impact on patient care by having interpreters that speak the same language as the patients. The management of the organisation should make this a priority to employ full-time interpreters in the labour and delivery ward. Quality care can only be provided if nurses understand the patient and vice versa. This would prevent miscommunication and mismanaged care and, therefore, patient and nurse satisfaction would be increased.

5.5.2 Provide Arabic/English classes for all new employees

Expatriate midwives coming to work in Saudi Arabia for the first time are anxious and have no knowledge of the Arabic language. Management of the organisation should have a plan in place to provide Arabic/English classes to all new employees that come to work in the organisation. Employees can be introduced to the Arabic language, reading material can be given as resources during these classes so that a reference can be kept if the employee wants to refresh and update themselves whenever they go to the wards, as not all information will be absorbed during these classes. Having this knowledge will make the expatriate nurses less anxious and more comfortable when they eventually go to the wards and start communicating with the Saudi patients. Learning the Arabic language not only prepares them for working inside the hospital, but it also makes them knowledgeable to socialise outside the hospital in Saudi Arabia.

5.5.3 Provide education in antenatal

Several studies have shown that if patients are informed and educated, they cooperate better and this leads to improved patient outcomes. All participants felt the need for patients to be educated in the antenatal clinic so that they understand their symptoms and plan of care when they are admitted to the labour and delivery ward. Top leaders in the organisation should provide interpreters and health educators in the antenatal clinics that will cover all education for the pregnant women. The labour and delivery ward is one of the busiest departments in the organisation in which 1 200 deliveries per year are conducted. Top management should be aware that expatriate midwives take care of two lives, not one. Therefore, this should be viewed as one of the priority decisions that should be made to bridge the communication gap.

It is understandable that patients cannot retain information if they are anxious or in pain, therefore education is a priority in the antenatal clinic. At the same time, resources like reading material can be given to the patients so that they can update themselves as the need arises with regards to nutrition, pain management and the symptoms of true and false labour.

5.5.4 Establish support groups for the expatriate midwives

Establishing support groups for the expatriate midwives is an over-arching recommendation that will support the other recommendations and experiences, as a whole. Working in a foreign, multicultural environment can be stressful for any healthcare worker. Expatriate midwives leave their countries, families and friends in search of a better career, living conditions and financial gain. Management should provide support groups to assist expatriate midwives to develop coping mechanisms to deal with the stress and a changing environment. They can have debriefing sessions, share experiences, learn from their co-workers'

experiences and preceptors. These support groups should be non-punitive and should enhance a positive, empathetic environment among group members.

Below is a diagrammatic representation of the themes, sub-themes and the recommendations of the study. The arrows represent the interaction of the solutions with the promotion of the sub-themes and themes in the proposed recommendations. The recommendation of establishing support groups for the expatriate midwives is an over-arching recommendation that will support the other recommendations and may facilitate communication as a whole:

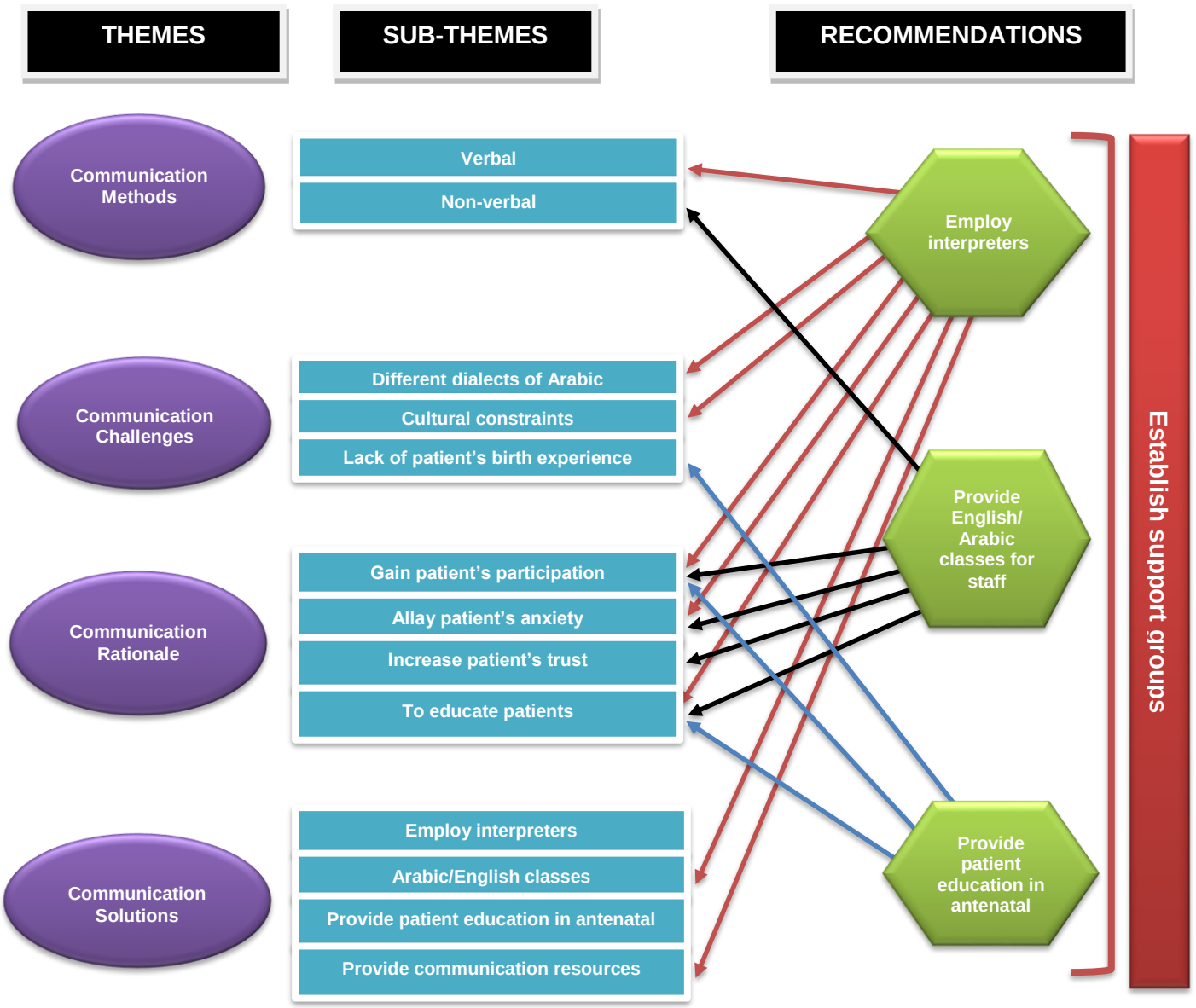

Figure 5.1: Visual representation of main themes and recommendations

5.6 Future research

The following research areas could be explored further:

- The relationship between the language barrier and patient outcomes in a Saudi setting in the labour and delivery ward
- The effectiveness of interventions (e.g. Arabic language classes, interpreters, antenatal education, etc.) and the impact of improving communication
- The lived experiences of Saudi labouring women being nursed by expatriate midwives.

5.7 Dissemination

The researcher will share her findings with the hospital management where the research was conducted. Findings will also be presented at the head nurses' meeting and perinatal meeting of the study setting hospital. The researcher plans to submit an article to a peer- reviewed journal in South Africa and the Saudi journal in Saudi Arabia.

5.8 Conclusion

In this chapter the findings of the study were discussed in relation to the study objectives. The research question was answered by the findings. Expatriate midwives used different communication styles when nursing Saudi patients. The literature review showed the different communication styles were verbal and non-verbal communication. Even though the expatriate midwives are not fluent in the Arabic language, they still provide maternity care to the pregnant women. However, the communication challenges remain the same globally amongst expatriate nurses. Regardless of expatriate nurses providing maternity care to pregnant woman, the daily communication challenges will affect the quality of care as experienced by participants of the study. The goal of providing a positive and safe birth experience to all pregnant woman should be the focus of all expatriate midwives. The focus should be to improve and sustain this goal in all pregnant woman.

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APPENDICES

Appendix 1: Ethical approval from Stellenbosch University

UNIVERSITEIT•STELLENBOSCH•UNIVERSITY
jou kennisvennoot • your knowledge partner

Approved with Stipulations
New Application

22-Jul-2016
Govender, Nelanie N

Ethics Reference #: S16/05/086

Title: **The role of communication in providing quality maternity care by expatriate midwives in a Military hospital in Saudi Arabia**

Dear Ms Nelanie Govender,

The **New Application** received on **10-May-2016**, was reviewed by members of **Health Research Ethics Committee 2** via Expedited review procedures on **22-Jul-2016**.

Please note the following information about your approved research protocol:

Protocol Approval Period: **22-Jul-2016 -21-Jul-2017**

The Stipulations of your ethics approval are as follows:
Technical

1. **Is Dr. Guin Lourens a co-supervisor? - not mentioned in application form.**
2. **HOD Signature says no, but it was signed by HOD.**
3. **The recruitment of participants (process) was not clearly stated in the protocol.**

Ethical

1. **The informed consent form: The contents are correct, but the two documents that were attached (the one called information leaflet and the other a participant info leaflet) need to be preferably merged as one informed consent form (or the distinctions need to be clearer).**
2. **It also needs to indicate the permission was also granted by the relevant health care facility.**

Please remember to use your **protocol number** (**S16/05/086**) on any documents or correspondence with the HREC concerning your research protocol.

Please note that the HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

After Ethical Review:
Please note a template of the progress report is obtainable on www.sun.ac.za/rds and should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit.

Translation of the consent document to the language applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372 Institutional Review Board (IRB) Number: IRB0005239
The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States
Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of
Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes
2004 (Department of Health).

Provincial and City of Cape Town Approval
Please note that for research at a primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape
Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western
Cape Department of Health (healthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr Helene Visser at City Health (Helene.Visser@capetown.gov.za Tel:
+27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics
approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.
For standard HREC forms and documents please visit: www.sun.ac.za/rds

If you have any questions or need further assistance, please contact the HREC office at .

Included Documents: invest declar M Bekker.pdf Information leaflet.pdf Synopsis of proposal.docx
RESEARCH PROPOSAL- 24 April 2016.doc
CV for Jessica revised.docx CV supervisor.pdf
Invest Declaration Dr G Lourens.pdf Participant info leaflet.doc
Invest Declaration J Morgan.pdf CV G Lourens.doc
Application form.pdf
Investigators declaration student Govender.pdf CV - Marilize Bekker.doc
HR Checklist.doc Sincerely, Ashleen Fortuin
HREC Coordinator
Health Research Ethics Committee 2

Investigator Responsibilities
Protection of Human Research Participants

Some of the responsibilities investigators have when conducting research involving human participants are listed below:

1. Conducting the Research. You are responsible for making sure that the research is conducted according to the HREC approved research protocol. You are also responsible for the actions of all your co-investigators and research staff involved with this research.

2. Participant Enrolment. You may not recruit or enrol participants prior to the HREC approval date or after the expiration date of HREC approval. All recruitment materials for any form of media must be approved by the HREC prior to their use. If you need to recruit more participants than was noted in your HREC approval letter, you must submit an amendment requesting an increase in the number of participants.

3. Informed Consent. You are responsible for obtaining and documenting effective informed consent using **only** the HREC-approved consent documents, and for ensuring that no human participants are involved in research prior to obtaining their informed consent. Please give all participants copies of the signed informed consent documents. Keep the originals in your secured research files for at least fifteen (15) years.

4. Continuing Review. The HREC must review and approve all HREC-approved research protocols at intervals appropriate to the degree of risk but not less than once per year. There is **no grace period.** Prior to the date on which the HREC approval of the research expires, **it is your responsibility to submit the continuing review report in a timely fashion to ensure a lapse in HREC approval does not occur.** If HREC approval of your research lapses, you must stop new participant enrolment, and contact the HREC office immediately.

5. Amendments and Changes. If you wish to amend or change any aspect of your research (such as research design, interventions or procedures, number of participants, participant population, informed consent document, instruments, surveys or recruiting material), you must submit the amendment to the HREC for review using the current Amendment Form. You **may not initiate** any amendments or changes to your research without first obtaining written HREC review and approval. The **only exception** is when it is necessary to eliminate apparent immediate hazards to participants and the HREC should be immediately informed of this necessity.

6. Adverse or Unanticipated Events. Any serious adverse events, participant complaints, and all unanticipated problems that involve risks to participants or others, as well as any research-related injuries, occurring at this institution or at other performance sites must be reported to the HREC within **five (5) days** of discovery of the incident. You must also report any instances of serious or continuing problems, or non-compliance with the HRECs requirements for protecting human research participants. The only exception to this policy is that the death of a research participant must be reported in accordance with the Stellenbosch Universtiy Health Research Ethics Committee Standard Operating Procedures www.sun025.sun.ac.za/portal /page/portal/Health_Sciences/English/Centres%20and%20Institutions/Research_Development_Support/Ethics/Application_package All reportable events should be submitted to the HREC using the Serious Adverse Event Report Form.

7. Research Record Keeping. You must keep the following research-related records, at a minimum, in a secure location for a minimum of fifteen years: the HREC approved research protocol and all amendments; all informed consent documents; recruiting materials; continuing review reports; adverse or unanticipated events; and all correspondence from the HREC

8. Reports to the MCC and Sponsor. When you submit the required annual report to the MCC or you submit required reports to your sponsor, you must provide a copy of that report to the HREC. You may submit the report at the time of continuing HREC review.

9. Provision of Emergency Medical Care. When a physician provides emergency medical care to a participant without prior HREC review and approval, to the extent permitted by law, such activities will not be recognised as research nor will the data

obtained by any such activities should it be used in support of research.

10. Final reports. When you have completed (no further participant enrolment, interactions, interventions or data analysis) or stopped work on your research, you must submit a Final Report to the HREC.

11. On-Site Evaluations, MCC Inspections, or Audits. If you are notified that your research will be reviewed or audited by the MCC, the sponsor, any other external agency or any internal group, you must inform the HREC immediately of the impending audit/evaluation.

Appendix 2: Permission obtained from institutions/Department of Health

المملكة العربية السعودية
وزارة الدفاع
رئاسة هيئة الأركان العامة
الإدارة العامة للخدمات الطبية للقوات المسلحة

الرقم :
التاريخ :
المرفقات :
الموضوع :

8 September 2016

To : Nelanie Govender
Clinical Instructor

Subject : **Request Approval for Research Project**

In reference to your application to conduct research titled **"The role of communication in providing quality maternity care by expatriate midwives in a Military hospital in Saudi Arabia"**, the members of the Ethics and Research committee have reviewed your proposal. After careful analysis, we have decided to grant you permission to conduct your research at the organization.

As chairperson of the Ethics and Research committee, I would like to wish you well in your studies.

Sincerely

Dr. Manar Al-Ruwaili
Acting Director of Academic Affairs and Training Administration
Chairman of the Ethics and Research Committee

Appendix 3: Participant information leaflet and declaration of consent by participant and investigator

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

TITLE OF THE RESEARCH PROJECT: Communication experiences in providing maternity care by expatriate midwives and pregnant women in a Military hospital in Saudi Arabia

REFERENCE NUMBER: 16267427

PRINCIPAL INVESTIGATOR: Miss Nelanie Govender

ADDRESS: **King Abdulaziz Airbase Hospital, Education Department, Saudi Arabia**

CONTACT NUMBER: **00966552596123**

Dear Colleague

My name is Nelanie Govender and I am the Clinical Instructor working in the Education department. I would like to invite you to participate in a research project that aims to investigate the communication experiences in providing maternity care by expatriate midwives and pregnant women in a Military hospital in Saudi Arabia

Please take some time to read the information presented here, which will explain the details of this project and contact me if you require further explanation or clarification of any aspect of the study. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the **Health Research Ethics Committee (HREC) at Stellenbosch University** and will be conducted according to accepted and applicable National and International ethical guidelines and principles, including those of the international Declaration of Helsinki October 2008.

The study will include all voluntary expatriate midwives working in the Labour and Delivery ward. Participants will have a face-to-face interview lasting approximately 30-40 minutes to discuss communication experiences between Saudi patients and expatriate midwives in providing quality maternity care in the Labour and Delivery ward. Interviews will be carried out by an independent field worker who works in another Military hospital and is qualified in the interviewing process. Participants will be interviewed on their off duty time at their accommodation to maintain privacy. The independent field worker will arrange a suitable time at the participant's convenience. Transport allowance for the field worker will be provided by the researcher. Snacks and beverages will be served after the interview process.

The anonymity of participants will be protected as no names will be used, participants will be given a number. Interviews will be carried out in English and will be recorded by a digital recorder. Electronic files of the interview will be saved on the researcher's computer and will be protected by a password. The researcher will only have access to the password, to maintain confidentiality. All data will be kept in a locked safefor a period of 5 years, thereafter all files from the computer will be deleted.

If you are willing to participate in this study please sign the attached Declaration of Consent and place it in the post-box available in the Labour and Delivery ward

Yours sincerely

Nelanie Govender Principal Investigator

Declaration by participant

By signing below, I …….. agree to take part in a research study entitled **"Communication experiences in providing maternity care by expatriate midwives and pregnant womenin a Military hospital in Saudi Arabia"**

.

I declare that:

- I have read the attached information leaflet and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) …….. On (*date*) …….. 2016.

……

Signature of participant

CONTACT DETAILS:

NATIONALITY: **NUMBER OF YEARS** **WORKING IN SAUDI ARABIA:**

Appendix 4: Interview guide

Interview Guide

University of Stellenbosch Interview Tool

Participant number:_____

Date:_____

Time:_____

1. How do you communicate with patients in the labour ward?

2. Why is it important to communicate with patients in the labour ward?

3. Identify your suggestions/solutions to overcome the communication challenges that you have experienced?

Researcher Notes

_____
_____
_____
_____
_____

Appendix 5: Extract of transcribed interview

Interview with participant 2

M	Ok, so like I said, the role of communication for providing quality maternity care in this hospital and the first question we want to ask you is 'How do you communicate with your patients in the labour ward'?	
P_2	Ummm. First time when we came here it was all our concern how we're going to communicate with them as we never been in this place before and we find out that also there are some patients that doesn't even know one word of English. So, we… first we use the the the tools that they gave us during orientation, like booklets, that they would tell us that at least these are the basic terms that you need to know just to greet and ask 'How are you' and you ask if she's having pain. Then after that, um, if it goes further it becomes a problem but then, ah, then in-between we use the sign language. That is it..and…	
M	Ok, so, hands…. Basically showing something like you want to know from the patient…	
P_2	Yes, but then sometimes you find that it drags the management that you give to the patient because sometimes the patient is giving you the time then you say 'Ok, wait a minute' – then you go back to what you were given during orientation trying to check out that is it exactly the time the patient said she started having pain.	
M	Ok	
P_2	You, understand. Then later on then we learn from the others that – from them, already there, but it was really a very frustrating time.	
M	So, when you – you're saying when you started when you came here, that was the very first time you were in the Kingdom.	
P_2	Yes.	
M	So you didn't know any Arabic and your patients didn't know any English?	
P_2	Yes.	
M	And you also said that you felt like it is keeping your work slow?	
P_2	Yes.	

M	Because you couldn't understand what they are saying.	
P_2	Yes.	
M	Ok.	
P_2	Then you have to go back and then when you come back to work, ah, you cannot sleep you just want to memorise those basic term – especially the time because you have to know what time the patient started having pain and where she's – ruptured membranes, what time – you know all those things. You come very frustrated, you come and memorize at least the basics that you can know.	
M	Yeah.	
P_2	Then at some stage you can see that there is a communication breakdown in-between the two or, between you and the patient.	
M	You could feel it.	
P_2	You can feel it because whatever she is trying to tell you, you try to reason and then with the sign language – but then still it doesn't make a sentence, it doesn't make a sentence, it doesn't make a, you know – ah, it doesn't make sense at the end of the day. Yes.	
M	Ok, so you said it caused you to, in the beginning, not to be able to sleep because you're thinking about studying this language and all these things.	
P_2	Yes.	

Appendix 6: Declarations by language and technical editors

SA Vryskutskrywer
jou eenstop Afrikaanse skryfportaal

Editing Certificate

November 28, 2017

I confirm that I have edited the following document for

NELANIE GOVENDER

Document title:

THE ROLE OF COMMUNICATION IN PROVIDING QUALITY MATERNITY CARE BY EXPATRIATE MIDWIVES IN A MILITARY HOSPITAL IN SAUDI ARABIA

Document type:

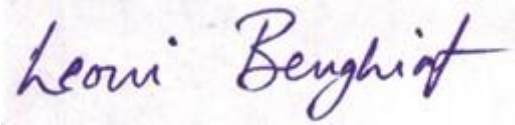
Master of Nursing Science in the Faculty of Medicine and Health Sciences Stellenbosch University

Editing services:

Full editing of whole document: correcting spelling and grammar mistakes; editing for consistency, style and flow, checking technical style and plagiarism

Editor: Leoni Benghiat / SA Vryskutskrywer

(Associate member: Professional Editors Group)



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E-POS: admin@savryskutskrywer.co.za
BESTUURDER: LEONI BENGHIAT

Lize Vorster Communication

To whom it may concern

This letter serves as confirmation that I, Lize Vorster, performed the technical formatting of Nelanie Govender's thesis entitled:

The role of communication in providing quality maternity care by expatriate midwives in a military hospital in Saudi Arabia.

Technical formatting entails complying with the Stellenbosch University's technical requirements for theses and dissertations, as presented in the Calendar Part 1 – General or where relevant, the requirements of the department.

Yours sincerely

Lize Vorster
Language Practitioner

Vygie street 9, Welgevonden Estate, Stellenbosch, 7600 * e-mail: lizevorster@gmail.com * cell: 082 856 8221