



## Article

# The Benefits and Barriers of Providing Non-Pharmacological Pain Relief to Women in Labour during COVID-19: A Qualitative Study of Midwives in South Africa

Limakatso Elizabeth Parkies <sup>1</sup>, Daphne Murray <sup>2</sup> and Uchenna Benedine Okafor <sup>3,\*</sup> 

<sup>1</sup> Department of Public Health, University of Fort Hare, 5 Oxford Street, East London 5201, South Africa; lizzyparkies24@gmail.com

<sup>2</sup> Department of Nursing Science, University of Fort Hare, 50 Church Street, East London 5201, South Africa; dmurray@ufh.ac.za

<sup>3</sup> Faculty of Health Sciences, University of Fort Hare, 5 Oxford Street, East London 5201, South Africa

\* Correspondence: ucheysonic@gmail.com

**Abstract:** Pregnancy is an exceptional event in a woman's life. As a result of the intense pain associated with childbirth, women require encouragement and support during this crucial phase. Midwives play a crucial role in the maternal care paradigm, managing labour pain alongside ensuring the mother and baby's safety during the labour process. This study explored midwives' perspectives concerning the utilisation and barriers of non-pharmacological labour pain reduction methods during COVID-19 in Matjhabeng Municipality hospitals in South Africa's Free State Province. Ten midwives participated in a semi-structured interview wherein the audio was recorded and transcribed verbatim. The data were analysed using Tesch's approach for open-coding data analysis. Midwives' experiences with non-pharmacological therapeutic options for relieving labour pain were varied. They used mobilisation techniques, warm bathing, deep breathing exercises, back massaging, and psychological support. Midwives affirmed that non-pharmacological labour pain interventions were poorly implemented because of staff shortages, heavy workload, and COVID-19 regulations at the time. In efforts to address the obstacles in managing labour pain and alleviate the pain of women during labour, midwives recommended the provision of education and advocacy, the employment of additional midwives and auxiliary staff, and improvement in hospital infrastructure. Due to staff shortages, heavy workloads, and COVID-19 restrictions that limit birth companions, non-pharmacological pain reduction methods are not properly implemented. Health education; employing additional midwives, professional doulas, and students; and improving health infrastructure are midwives' concerns. Prioritising midwife training in non-pharmacological labour pain management is crucial for delivering the best possible care during childbirth.

**Keywords:** non-pharmacological; midwives; labour pain; relief options



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## 1. Introduction

Pregnancy for a woman is a distinct experience. Due to the intense pain associated with childbirth, women require encouragement and support in this critical phase. Nevertheless, the intensity of pain is subjective and dependent on other underlying factors specific to each woman. The World Health Organisation (WHO) [1] has emphasised the need for non-pharmacological techniques as a risk-free method to alleviate labour pains and reduce the use of medications during childbirth. Thus, it remains a challenge for midwives to provide labour pain relief to labouring women so as to alleviate their intense labour pain without affecting the labour process, mode of delivery, neonatal outcome, or parturient safety.

Notably, non-pharmaceutical labour pain measures provide numerous advantages. They are less expensive and more simply implemented, and they assist women in the

decision-making process (regarding the choice of whether or not to take pain medication) [2]. Women who receive non-pharmacological palliative care experience minimal pain during childbirth and are unlikely to be susceptible to drug interventions. Moreover, non-pharmacological pain relief options during labour improve connection with birth professionals and birth companions [3]. Effective and safe for the mother, foetus, and labour are non-pharmacological pain relief options during childbirth [4]. Thus, from a clinical standpoint, it is advantageous and safe to use non-pharmacological palliative treatments for labouring women. According to global estimates, 73% of women utilise no less than one non-pharmacological pain management approach during labour [5]. Non-pharmacological methods for alleviating labour pain encompass a range of techniques. These include deep breathing exercises [5–9], the utilisation of a birthing ball for exercise [10–12], engaging in prayer or meditation [8], applying heat therapy [7,13], and back and sacral massages [5–7,13]. Others, however, include music therapy [7,14], positions or posture change [5,6], acupuncture [13,15,16], and aromatherapy (use of essential oils) [17]. Transcutaneous electrical nerve stimulation (TENS) [18], sterile water injection [19], and psychological support [5,6,20] are also used to relieve labour pains. Additionally, contact therapy reduces labour pain and anxiety among mothers [21,22]. In their systematic review, Cabral et al. [7] noted that thermal therapy, massage, aromatherapy, acupressure, dance, and swill ball exercises were the most effective non-pharmacological strategies for alleviating labour pain, as well as providing relaxation, comfort, and anxiety relief with less medication use. The pain associated with childbirth is intense and is accompanied by fear, physiological stress, and anxiety. Therefore, efforts by midwives to use non-pharmacological means to alleviate labour symptoms during the birthing process are encouraged to avoid the adverse effects associated with drug-based therapeutic methods.

Midwives are professional nurses who play a crucial role in boosting maternal and newborn health; they also work to promote safe birth for both the mother and the baby; hence, Lundgren and Dahlberg [23] described them as “anchored companions”. An individual who has fulfilled the requirements of midwifery education at an accredited nursing college or university and obtained registration with the South African Nursing Council (SANC) is considered a midwife in the context of South Africa [24]. The SANC regulates the scope and practice of midwives, requiring them to deliver a variety of maternal health services to women in both clinical and non-clinical settings. Midwives are obliged, depending on their degree of training, to promote, maintain, restore, and support women’s health during pregnancy, labour, and the puerperium, as well as the newborn baby [24]. However, due to the lack of obstetrics health providers in South Africa, midwives are overworked, particularly in the public health sector. As a result, nurses are occasionally sent to maternity healthcare settings to supplement the scarcity of midwives. In South Africa, there is a need for enhanced working conditions for midwives to ensure that they can deliver high-quality healthcare during childbirth.

Midwives in South Africa employ non-drug approaches to relieve women’s labour pains, including emotional support, back rubbing, and deep breathing exercises [25,26]. Notably, differing contextual paradigms may influence midwives’ attitudes and behaviours in offering non-pharmacological labour relief pain treatments based on prevalent sociocultural, health policy, and health system challenges in a particular geographic area. This, in turn, could leave midwives in a dilemma about which labour relief option to use in a clinical setting. Previous research has documented the concerns of midwives and nurses regarding the baby’s arrival during exercising, changing posture, walking, and stereotypical misunderstandings regarding labour pain, considering it as an inevitable part of the birthing process [6]. Furthermore, a lack of understanding about the available non-pharmacological methods for reducing childbirth pain may limit midwives’ and other healthcare providers’ ability to provide such to women during labour. Midwives’ lack of knowledge, belief in effectiveness, training, and education; the availability of clinical guidelines; and the lack of resources could hamper their efforts to implement non-pharmacological pain relief interventions in labour pain management [4,27,28]. To facilitate an optimal childbirth

experience for women, the World Health Organisation endorses mobilisation and upright positions during labour, the presence of supportive delivery companions, and the provision of compassionate and trained carers [1]. Therefore, understanding midwives' attitudes on non-pharmacological choices for pain relief during childbirth is vital for guiding what kinds of interventions are relevant and improving their actions on this subject matter. However, research on midwives' perspectives on the use of non-pharmacological labour pain management in South Africa is limited, with only one study available [29]. As a result, the current study explored midwives' perspectives concerning the benefits and barriers of non-pharmacological pain reduction measures for childbirth during the COVID-19 period in Matjhabeng Municipality hospitals in South Africa's Free State Province.

## 2. Results

The participants were all black female midwives ( $n = 10$ ) with extensive professional experience in midwifery (ranging from 3–27 years) and between 28 and 55 years. The participants had diplomas in Nursing (General, Psychiatry, and Community) and Midwifery. They were responsible for providing safe, maternal healthcare to women in the wards/antenatal care.

The identified themes and subthemes centred on the participants' positive and negative experiences, challenges, and suggestions for improving non-pharmacological approaches to labour pain management.

### Theme 1: Experiences using non-pharmacological methods

Midwives rarely reported utilising non-pharmacological approaches to help women ease birth pain, believing them to be beneficial. These include mobilisation exercises, warm baths/showers, breathing exercises, and back rubs. The above-cited techniques serve to distract attention from the source of the pain and have a calming effect, as they maintained:

*“Non-pharmacological pain relief is still working like mobilising the patient, sending the patients to the shower, as well as deep breathing” (MW 3).*

*“Every patient is different. We usually use the rubbing method. We let them walk, take a shower, and then do breathing exercises” (MW 4).*

*“We also encourage them to take a warm bath because it does help with pain management” (MW 6).*

The presence of companions assists in back massaging and facilitates continuity of care.

*“We used to allow patients to bring in their companions, who were helpful in rubbing the patient's back and helping with continuity of care. They can even call you if the woman requires your assistance” (MW 3).*

*“During the times before COVID we used to allow companions and we would ask them to rub the woman. The rubbing method were working well because the husband or the mother will be there” (MW 5, 7, 10).*

### Theme 1.1: Negative experiences

According to some participants, non-pharmacological treatments are sometimes ineffective in decreasing labour pain as compared to pharmacological therapies, as women occasionally continue to experience labour pain.

*“We do not encourage the use of pharmacological interventions, but non-pharmacological interventions are more effective when combined with pharmacological interventions for certain women” (MW 3).*

*“This method is like drug treatments, but each patient is different; it works for some but doesn't for others” (MW 4).*

A few participants also mentioned that non-pharmacological approaches, such as warm showers, might often exacerbate pain rather than ease it. Midwives allowed birth companions to be present to provide emotional support to the women.

*“Then, after taking a warm shower, I noticed that the woman’s pains got worse instead of better” (MW 2).*

*“Some say the pain is worse after taking a bath” (MW 6, 7).*

### **Theme 2: Challenges of non-pharmacological pain relief**

The insufficient availability of staff contributes to suboptimal pain treatment, leading to the poor provision of necessary care for women. This can result in women becoming intolerant and experiencing increased discomfort with each contraction, which can lead to complications such as foetal distress. Most participants expressed awareness regarding their responsibilities; yet, due to a scarcity of personnel, they encountered difficulties in successfully addressing labour pain. As a result, many people avoid receiving back massages.

*“We don’t do massaging because of shortage of staff” (MW 7).*

*“We are also unable to rub/massage the woman because of lack of time and shortage of staff” (MW 9, 10).*

Most respondents indicated that, due to COVID-19 restrictions, they did not permit birthing mothers to be accompanied by companions. This presents a difficulty, as a partner may assist with non-pharmacological therapies, such as back massages and emotional support.

*“Because of COVID restrictions, we don’t have the companions right now” (MW 5).*

*“Since COVID-19 began, we are not letting the companion in, which is bad for us because they used to help us rub” (MW 6, 8).*

According to some participants, due to cultural beliefs, some African women choose not to have birth partners.

*“The challenge is that not all of them who are coming with a companion. Our Black patients are not coming with their companions; only few are coming with a companion” (MW 4).*

*“We do allow companions, but it is extremely rare; the patients always come alone. I would say that only a few out of every five people come with a friend or family member” (MW 6).*

Most participants reported that some women were hesitant, uncooperative, and unwilling to move or perform breathing exercises. Some women do not take advantage of available facilities, which include warm bathing or mobilising, because they view these activities as punishment instead of a benefit.

*“Sometimes, patients are hesitant to move because they don’t understand why the sister says I have to walk when I’m in pain. They are irritable and do not comprehend why they should take a warm bath, even when we explain why they should” (MW 6).*

*“The patients sometimes do not cooperate in terms of mobilising breathing exercises because they don’t understand why they should do it” (MW 9, 10, 11).*

*“You’ll tell mam go take a bath, sit in there for as long as you can or for about 30 min then you go and attend to another patient, not even five minutes, then the patient is out from bath” (MW 6, 7, 8).*

Women are frequently unable to take a warm bath or shower due to shortages of warm water in maternity wards.

*“Sometimes there will be no warm water; they will come back saying sister you said I should take a shower, but it’s only cold water” (MW 1, 2, 10).*

Some participants noted that the lack of space in labour wards prevented them from encouraging physical activity among women.

*“We are unable to conduct the exercises due to a lack of space and also staffing owing to the fact that you must be present” (MW 4).*

### Theme 3: Suggestions: Improvements in non-pharmacological usage

Midwives suggested educating women; increasing the number of midwives, doulas, or students; providing the necessary facilities; and combining the two pain management approaches. Midwives acknowledged that women may decline non-pharmacological pain treatment techniques because of inadequate awareness, therefore emphasising the importance of educating women on this subject.

*“With non-drug methods, I think the patients need to learn more about what will happen during labour” (MW 6).*

*“I think that during prenatal care, we should let them know about the pain they will be experiencing and the non-pharmacological interventions that will assist them. This will help improve the support during labour” (MW 8, 9).*

Most respondents believed that having some extra staff would assist them in carrying out their responsibilities, managing pain, and supporting women.

*“We need more staff because you will find yourself alone with more than one patient at times” (MW 6, 10).*

*“First and foremost, if we have adequate staff, as they say, the rule is that one midwife equals two” (MW 7).*

One participant suggested:

*“Maybe I should say more staff, even if it’s just lower-level staff; we can always teach them” (MW 4).*

Participants stated that non-pharmacological pain management approaches are ineffective on their own but considerably more effective if utilised with pharmacological ones.

*“We do not encourage the use of pharmacological interventions, but non-pharmacological interventions are more effective when combined with pharmacological interventions for certain women” (MW 3, 4).*

Some midwives advocated for the installation of showers. Existing wards provide only two functional showers for labouring women. COVID-19-positive mothers are required to use these showers, which makes them dangerous.

*“I don’t know, though, because what we have now works. Maybe if we can have more showers” (MW 5).*

Participants advocated for the hiring of doulas and the recruitment of students to assist with non-pharmacological methods.

*“But then it will be better if there is someone to help. In this case, getting the doulas, even though they are not professionals; they will be trained on how to give this non-pharmacological pain methods for labour pain. I think students can also be recruited to help with this. This will help a lot” (MW 4).*

## 3. Materials and Methods

### 3.1. Study Design and Participants

This qualitative descriptive study included ten purposively selected midwives who were approached by the principal author (L.E.P.) to participate in the study. Notably, the number of midwives assigned to maternity units is negligible. After being informed of the study’s objectives and details, only those midwives who expressed their consent to partake in the interviews were granted inclusion. To participate in the study, participants were required to have at least five years of working experience, be employed in maternity units, and sign an informed consent form.

### 3.2. Study Setting

The participants were interviewed at two district hospitals in Matjhabeng Municipality, Lejweleputswa District, Free State Province of South Africa. The population of the

Lejweleputswa District is projected to be 42,913 [30]. The Matjhabeng Municipality has three district hospitals, one regional hospital, three private hospitals, and day clinics, but none of them offer intrapartum care unless there is an emergency. The maternity wards of Katleho and Thusanong District Hospitals in the Lejweleputswa District were selected due to their unique feature of being resource-constrained district hospitals in the region.

### 3.3. Data Collection Procedure

Participants were provided with an informed consent form, and those who consented to participate were requested to return signed consent forms and demographic questionnaires to the principal author. They were then notified by phone about the interview date, time, and venue. A guided semi-structured interview captured participants' experiences and challenges with non-pharmacological labour pain management methods, as well as their opinions on how to enhance labour pain management. Individual interviews with ten individuals lasted between 40 and 60 min. The audio-recorded individual interview was transcribed verbatim and then compared to the field notes.

Several procedures were implemented to ascertain the trustworthiness of the data as described by Rana et al. [31]. The member verification, audio trial, and transcribed data were frequently checked for accuracy with the audio-recorded interviews. To ensure the study's credibility, the research objectives and procedures were carefully presented to participants in a courteous manner to develop a trusting connection. As a result, LEP spent enough time interviewing the participants to ensure long-term involvement. Data were collected directly from the participants using notes and an audio recorder. The interview guide was utilised for all ten participants, and the second author (D.M.) ensured the accuracy of the information gathered and transcripts to uphold confirmability. In addition, the purposeful sampling of participants provided relevant information on the subject until data saturation was reached. In-depth details of the study's data-gathering processes, including the key features of the study participants, were provided. Furthermore, the interview transcripts were made available to the participants for the verification and accuracy of the identified themes. Also, an audit trail was established to determine the verbatim descriptions, categories, and subcategories of the themes noted through data analysis. Furthermore, an independent coder reviewed the data, and the transcripts and themes were all endorsed by all participants. Finally, to ensure the thorough and transparent reporting of qualitative research, we anchored the study design and procedure for reporting results on the guidelines stipulated by the Consolidated Criteria for Reporting Qualitative Studies (COREQ) [32].

### 3.4. Data Analysis

The data were analysed using the Tesch technique [33]. The interviews were thoroughly studied to acquire a complete knowledge of the facts. Following that, a document was created that included the most concise and complete details about each subject matter. In addition, a list of all subjects, comparable themes, and clustering was compiled. The themes were coded and then condensed, and the codes were then placed next to the appropriate parts of the text. The most descriptive terms for each topic were identified, and the topics were organised into thematic groups. The coded first-order analysis was carried out, and the data corresponding to each group was organised correspondingly. The identified main themes and subthemes were confirmed by the researchers and the independent coder.

### 3.5. Ethics

The University of Fort Hare's Health Sciences Ethics Research Committee (HSERC) granted ethical approval (Ref# 2021 = 05 = 02 = ParkiesL). In addition, the Eastern Cape Provincial Department of Health Ethics Research Committee authorised the protocol and granted researchers permission to conduct the study in the approved health facilities. The nature and purpose of the study were explained to the participants, who provided written

informed consent. The identities of the participants were concealed for confidentiality and privacy.

#### 4. Discussion

This study explored the experiences of midwives regarding the benefits and barriers of non-pharmacological options for pain alleviation during labour in hospital settings in Matjhabeng Municipality, Free State Province, South Africa. This study found that non-pharmacological strategies used by midwives to assist women in coping with childbirth pain include mobilisation exercises, warm bathing, and breathing exercises. This study's findings are consistent with earlier studies that have reported similar findings [5–9,13]. Clearly, the use of only these non-pharmacological labour pain management choices implies that midwives are unfamiliar with the numerous non-pharmacological ways for reducing labour pain, or that midwives are unaware of their applicability. This suggests that midwives should be educated and trained to equip them with enough information and understanding of the many non-pharmacological labour pain-reducing techniques available, as well as methods of offering them. Midwifery training is essential for improving midwifery care [34]. Midwives play an essential role in childbirth; they ought to ensure that women have a more comfortable, pain-free, and satisfying birth experience. They are a gateway to optimal maternal birth and health outcomes; consequently, knowledge of the comprehensive, supporting, and caring birthing process is crucial in this regard.

Our finding also supports previous research that found midwives to be supportive and calming companions and expectant women during the labour process [5,6,20,35]. Other research has found that midwives use doulas in the birthing process to offer physical and emotional support [36]. Non-pharmacological therapies are effective in lessening pain during childbirth while causing no adverse effects to both the woman and the baby, or the labour process [4]. Most midwives contend that these procedures are less effective by themselves due to women's unwillingness to utilise them; hence, such procedures are frequently employed in tandem with pharmacological strategies. In their systematic review, Beyable et al. [37] affirmed that a blend of non-pharmacological options and a smaller number of selected pharmacological methods of labour pain interventions provides significant benefits to women and their babies. Non-pharmacological labour pain treatment options are effective and safe for the mother and foetus and in reducing the effects of labour and childbirth, including pain, the duration of labour, anxiety, laceration, and episiotomy [3,4,38], and they are less expensive and simple to implement [2]. However, many of the non-pharmacological labour pain relief methods such as music therapy, acupuncture, aromatherapy (use of essential oils), transcutaneous electrical nerve stimulation (TENS), sterile water injection, contact therapy, dance, and swill ball exercises were rarely or not mentioned by participants in our study, which underscores midwives' lack of knowledge and awareness on these non-pharmacological labour pain strategies. Similar findings have been reported elsewhere, including in Tanzania, Iran, Ethiopia, and Ghana [4,6,25,39,40]. There is a need to educate and raise awareness regarding non-pharmacological pain management strategies so that midwives can broaden the scope of utilisation of other non-pharmacological labour pain relief options beyond what they seemingly understand and practice, which is probably due to a lack of knowledge.

The midwives favoured non-drug methods but acknowledged barriers such as staff shortages, inadequate training, and inability to always obtain cooperation from labouring women. Staff shortages prevent midwives from delivering individual care and monitoring; examples abound in which a midwife urges a woman to breathe throughout a contraction; however, when she turns to assist the other patient, the woman pushes with each contraction, creating unnecessary complications. This is not a unique finding; previous research has linked the shortage of midwives to the poor utilisation of labour pain treatments, as well as staff shortages and work-related frustrations [4,27,28,35,41]. The shortage of midwives highlighted in this study emphasises the need to deploy lower-level nurses, such as nursing assistants, to provide support.

Another challenge was COVID-19 restrictions, which prohibit companions from accompanying patients to the hospital; this has a severe influence on midwifery care and labouring woman support. Notably, COVID-19 created a disastrous scenario because both physical and social distancing measures disallowed accompanying persons during birth, resulting in substandard childbirth experiences [42]. Cultural and religious beliefs may also have played a part. Certain cultures do not allow partners to accompany women during the childbirth process. This is especially evident among Arab women [43]. Notably, males are not permitted to observe women giving birth in certain African black cultures; despite their level of education and enlightenment, some males continue to view their presence during childbirth as taboo and refuse to participate in the process. According to Klomp et al. [44], cultural beliefs regarding labour pain relief among women from Africa and the Netherlands hinder the midwives' ability to effectively coordinate labour pain and assist women in managing their labour pain, as they are required to possess a wide variety of culturally appropriate support skills. In addition, the religious beliefs and practices of women influence Ghanaian's women decision to embrace non-pharmacological labour pain relief [25]. Nonetheless, midwives appreciate maternity ward companions because they may assist with activities such as back massages and emotional support, allowing mothers in labour to benefit from individualised care. Personnel shortages, as already mentioned, exacerbate the problem.

Furthermore, the midwives in our study reported a lack of cooperation from labouring women regarding the use of non-pharmacological therapies. Women's lack of knowledge regarding non-pharmaceutical labour pain strategies would result in uncooperative attitudes and the ineffectiveness of the procedures. Consequently, the antenatal preparation and education of women are essential. According to Aziato et al. [25], antenatal education on the usage and benefits of non-pharmacological therapies for labour pain management is lacking. Midwives can empower women by detailing the pain management choices available during delivery during antenatal appointments so that women fully comprehend what is expected of them and how to apply these measures to their own situations [45]. To effectively develop contextual strategies that empower and assist women during labour pain, it is critical to comprehend their viewpoints concerning the utilisation of non-pharmacological pain alleviation during childbirth. Nevertheless, this specific facet was outside the scope of the present study; thus, further study is necessary to explore it.

Another barrier to non-pharmacological pain management was a lack of healthcare facilities and infrastructure. The midwives emphasised that the lack of warm water, bathtubs, bathrooms, and an exercise room severely inhibits the women's ability to utilise these to ease labour pains. Quality maternal health services necessitate a focus on the human and material resources of the nation or health institution. In the studied settings, there are very few labour rooms; consequently, patients frequently share a room. Due to a lack of space and privacy, midwives are unable to use certain non-pharmaceutical techniques. Therefore, efforts should be made to improve the resources in this context so that midwives can provide effective services to women during childbirth and even postpartum.

According to our study findings, the midwives emphasised the importance of recruiting more midwives, doulas, or students; enhancing healthcare facilities; and combining non-pharmacological and pharmacological methods for labour pain relief. The recommendations made by the participants echo those made by midwives in other settings [41,45]. Similarly, Pietrzak et al. [2] underscored the necessity of implementing educational initiatives aimed at augmenting an evidence-based understanding of pain relief techniques during labour among women. The employment of additional midwives will inevitably reduce their workload. Similarly, negligence in addressing infrastructural challenges in a health system results in the delivery of poor-quality healthcare, highlighting the need to provide adequate resources to support midwives to effectively provide labour pain interventions to women [46]. Companions or doulas play a crucial role in providing confidence and emotional support to individuals while also supporting midwives who may be facing staffing shortages. This assistance can include tasks such as providing back massages.

## 5. Implications

The findings provide context-specific information for the Free State Department of Health to aid policymakers and stakeholders in developing relevant policies, guidelines, and interventions to improve labour pain management. Improved labour pain therapy will lessen complications for mothers and their newborns, resulting in fewer lawsuits and expenditures for the Department of Health. Thus, addressing the shortage of manpower, enhancing infrastructure, and providing training to midwives on various non-pharmacological techniques is desirable. Understanding that midwifery is a caring endeavour, midwives should empathetically administer non-pharmacological pain relief measures as part of the maternal care/birthing experience by putting the patient at the central stage.

## 6. Limitations

Since the study was conducted in one geographical area in South Africa, these results cannot be generalised; but it offered insights on improvements concerning midwife training in South Africa and the need for more well-trained midwives. In addition, the inherent limitation of self-reporting associated with interviews concerning honest views cannot be ruled out. Also, we were unable to explore the perspectives of patients or women; thus, further study is required. We were also constrained to conduct focus-group discussions because of the COVID-19 restricted protocol of social distancing and gathering. Nevertheless, the findings of this study provide a snapshot of the experiences of midwives regarding the benefits and barriers of non-pharmacological labour pain management initiatives in resource-limited geographical settings with implications to direct policy action and improve practice.

## 7. Conclusions

The findings of this study indicated that midwives used mobilisation, a warm bath, deep breathing exercises, and back massages as non-pharmaceutical methods to assist women in labour pain relief. However, midwives were constrained by staff shortages resulting in excessive workload, inadequate training, and inability to always obtain cooperation from labouring women during the birthing process. The midwives advocated for health education/advocacy; the employment of additional midwives, professional doulas, and students; and improvement in health infrastructure facilities. Our findings highlight the importance of prioritising midwife training on non-pharmacological labour pain relief options as part of maternal efforts to provide quality healthcare to women, particularly during the critical period of childbirth.

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**Informed Consent Statement:** Informed consent was obtained from all subjects involved in the study.

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