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Midwives' experiences of working conditions, perceptions of professional role and attitudes towards mothers in Mozambique

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ABSTRACT

Background: low- and middle-income countries still have a long way to go to reach the fifth Millennium Development Goal of reducing maternal mortality. Mozambique has accomplished a reduction of maternal mortality since the 1990s, but still has among the highest in the world. A key strategy in reducing maternal mortality is to invest in midwifery.
Aim: the objective was to explore midwives' perspectives of their working conditions, their professional role, and perceptions of attitudes towards mothers in a low-resource setting.
Setting: midwives in urban, suburban, village and remote areas; working in central, general and rural hospitals as well as health centres and health posts were interviewed in Maputo City, Maputo Province and Gaza Province in Mozambique.
Method: the study had a qualitative research design. Nine semi-structured interviews and one follow-up interview were conducted and analysed with qualitative content analysis.
Results: two main themes were found; commitment/devotion and lack of resources. All informants described empathic care-giving, with deep engagement with the mothers and highly valued working in teams. Lack of resources prevented the midwives from providing care and created frustration and feelings of insufficiency.
Conclusions: the midwives perceptions were that they tried to provide empathic, responsive care on their own within a weak health system which created many difficulties. The great potential the midwives possess of providing quality care must be valued and nurtured for their competency to be used more effectively.

Introduction

The UN's Fifth Millenium Development Goal was to reduce maternal mortality by three quarters, which, in many countries, had not been fulfilled by the proposed target date of the end of 2015 (UN, 2014). The process of forming the post-2015 agenda and the next set of sustainable development goals have now taken place, and a challenge is to give appropriate attention to sexual and reproductive rights and health (Haslegrave, 2014, https://sustainabledevelopment.un.org/?menu=1300). Giving women access to skilled birth-attendance, facility births, family planning, maternal health care with ante- and postnatal visits access to safe abortion are issues of vital interest to these developments. A functioning system for referral along with a focus on training, retention and deployment of health personnel, and working for gender equality are also important parts of the process (UN, 2014; Say et al., 2014; Requejo et al., 2015).

Mozambique is one of the world's poorest countries, but has reported a rapid decrease in maternal deaths since the 1990s coupled with an increase in the deployment of midwives (Van Lerberghe et al., 2014). The ratio of maternal mortality decreased from 1300 per 100,000 in 1990 to 480 in 2013; but this is still among the higher numbers in the world. This rate might be affected by, although measures are taken to prevent it, by the low level of skilled birth attendance and insufficient access to emergency obstetric care. Fifty-four per cent of the women who give birth do not have access to a skilled birth attendant, by poorest quartile 32% and by richest quartile 90%, in 2011 (UNICEF STATISTICS, 2016).

The majority of maternal deaths occur during the intrapartum period, making the focus on this particular period a key component. The best and most cost-efficient strategy for first-level

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intrapartum care isbirths in health centres, dominated by midwives, but with other categories of personnel participating in the team (Campbell et al., 2006). Midwives play a key role in global strategies for the provision of maternal health care. Professional midwives have the ability to bring care closer to the woman, both physically and socioculturally (ten Hoope-Bender et al., 2014), and to reduce several risks of complications connected to giving birth that can lead to mortality or severe morbidity such as severe blood loss and perineal trauma (Van Lerberghe et al., 2014). An analysis of 461 reviews of the effectiveness of practice shows that a majority of practices that are effective are in the midwife's repertoir (Renfrew et al., 2014), and *State of the World's Midwifery* 2014 states that midwives can provide almost 90% of essential care for mothers and newborns (UNPFA et al., 2014). A shift from a health system focused on finding pathologies to one providing skilled care for all is a key strategy, and the midwives are integral to this element (Renfrew et al., 2014). The International Confederation of Midwives (ICM) definition of the midwife and its code of ethics (ICM, 2008a) state, in relation to the midwife's professionality and responsibility, that the midwife is an autonomous provider of care taking responsibility for their own actions and showing competency within midwifery, working respectfully together with midwives and other categories of staff, and who have "responsibilities to themselves as persons of moral worth".

Midwifery is crucial for improvements in the quality of maternal health care, and comprises more than just one dimension. There are the aspects of technical competencies and proficiency in the use of equipment, as well as combining inter-personal skills with responsiveness, and having knowledge of the organisational structure and its facilities for appropriate referral (ten Hoope-Bender et al., 2014).

Midwives are important in providing person-centred care with high quality. The care midwives can provide should fit with the goals to encourage normal reproductive health, avoid over-medicalisation of birth (Campbell et al., 2006), improve health outcomes and empower women (ten Hoope-Bender et al., 2014). However, a growing body of research and empirical information reveals evidence of malpractice in delivery service, such as the disrespectful treatment and abuse of women who are birthing. Therefore, several statements have been made from influential organisations, such as WHO, FIGO and the White Ribbon Alliance, addressing the importance of improving the interpersonal quality of care so as to be more responsive towards the needs and wishes of women. A charter regarding respectful maternity care – signed by WHO, ICM and FIGO, among others – stating the universal rights of childbearing women and based on conventions and declarations of human rights was developed in 2011 (FIGO et al., 2015). These rights are; the "right to freedom from harm and ill treatment, right to information and informed consent and respect for choices and preferences, right to confidentiality and privacy, right to dignity and respect, right to equality and freedom from discrimination and equitable care, right to timely health care and the highest attainable level of health as well as right to liberty, autonomy, self-determination and freedom from coercion." This statement fits well with the ICM philosophy and model of midwifery care as well as the ICM international code of ethics for midwives (ICM, 2008a, 2008b). Midwifery is a groundstone in process of accomplishing safe births and the challenges for midwives are especially demanding in constrained settings. Hence, there are several further dimensions of their professional performance that should be placed in focus. The aim of this study was to explore midwives' perspectives of their working conditions, their professional role, and their attitudes towards mothers in a low-resource setting. By exploring these perspectives, more knowledge is gained about the needs of midwives to optimise their function in their professional role and how to most effectively ensure fulfilment of the human rights of mothers.

Method

The study followed a qualitative research design (Dahlgren et al., 2004). Semi-structured interviews were chosen as the most appropriate method to address midwives working experiences and their perceptions of mothers in a low-resource setting. The data were interpreted and discussed using an ethical framework of the universal rights of childbearing women, the ICM definition of the midwife, and the ICM code of ethics for midwives (ICM, 2008a, 2008b).

Settings

Data collection took place in four different types of environments – urban, suburban, village and remote – in three southern provinces in Mozambique; in Maputo City, Maputo Province and Gaza Province. Maputo City is the capital of Mozambique having 1.7 million inhabitants mainly living in the urban environment and almost 90% of births are facility births. Maputo province consists of both of urban/periurban and rural environments with heterogenous living conditions and with, for example, a rate of 80% facility births in the village of Manhica. Gaza Province consists mainly of rural areas, has one of the country's highest poverty rates, and a facility birthrate of 60% (Table 1).

Participants

Mozambique's equivalents to midwives are called maternal and child health nurses, who each have received a different quantity and quality of training. The most senior level has four years of training at university level, and the medium and basic levels have two and one years, respectively, in health training centres. These categories of personnel are hereafter referred to as midwives.

Midwives in different workplaces were purposively sampled with the help of midwife coordinators from the local health ministries. In the remote area of Gaza Province, midwives were recruited with the snowball method.In Maputo Province the midwives were working in health centres and maternity care centres in a suburb of Maputo City, and in a rural hospital situated in a village 80 km outside the city. In Maputo City the midwives were working in a general hospital and a central hospital within the city. In Gaza Province the midwives were working in health posts and health centres in a remote area – one of the province's poorest and least populated.

The majority of the midwives were between 20 and 35 years old with 1–5 years of working experience. Two informants were older (40–55 years) with ten and 40 years of working experience, respectively. Most of the midwives had medium-level education and two had basic level (Table 2).

Data collection

Nine midwives were interviewed. One supplementary interview was also performed with one of the midwives who gave particularly reflective and open answers. Each interview lasted between 40 and 90 minutes. The interviews took place during the midwives' working hours and mainly in private treatment rooms,

Table 1
Population density, percentage facility birth and time of referral by setting.

	Urban	Suburban	Rural	Remote
Population density per km^2	5100	2400	82	1–4
Facility births	90%	90%	80%	60%
Time to referral hospital by car	< 1 h	< 1 h	1,5 h	7 h