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BARRIERS TO PROVISION OF COMPETENT MIDWIFERY CARE IN RURAL ZIMBABWE: SUPERVISORS' PERSPECTIVE'

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ABSTRACT
Competent midwifery care entails provision of basic essential care, early detection, management and referral of selected emergencies as stipulated in the midwifery practice standards and ICM essential competences. Loosing life while giving life has become a global concern with Zimbabwe recording 47% preventable deaths in 2015. The aim of this study was to explore what the midwives' supervisors and key stakeholders perceive as barriers to provision of competent midwifery care in rural maternity units in Zimbabwe. This qualitative descriptive study was based on interpretive paradigm Interviews and focused group discussions (FGD) with 13 immediate supervisors from six health care institutions and key informants from province and national organizations were held with an interview guide. Both interviews and FGD were audio recorded and transcribed verbatim. Content analysis following basic steps of abstraction, creating codes, sub-themes and finally themes was done manually to ensure Data trustworthiness and credibility of findings. Four themes yielded included unstandardized education system, unclear practice parameters, lack of professional recognition and supportive environment. The adoption of a scope of practice framework for competence midwifery practice by the regulatory authority will provide the much needed light at the end of the tunnel for midwifery education, regulation and practice in Zimbabwe.

Key Words: Barriers, competent midwifery practice

INTRODUCTION
Provision of competent midwifery care can be the key strategy to curb the high preventable maternal deaths scourging the nation and improve pregnancy outcomes. Though the causes may be multifactorial, lack of competent, motivated midwifery workforce is among the commonly cited factor in public media and several studies revealed evidence of significant contribution midwifery care can make to improve pregnancy outcomes for women and their infants. (1: 2) Nationally the introduction of nurse/ midwife led initiation of Anti-retroviral treatment has paid dividends in the reduction of the nation HIV burden. This shows that midwives if given the autonomy and support can make a difference.

Several strategies have been put in place to try and intervene for the high maternal and neonatal mortality rates which remains unacceptably high and threatening the national as well as professional integrity. Ministry of health and child care of Zimbabwe (MOHCCZ) in 2015 developed a strategic

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direction for Nursing and Midwifery (SDNM 2016-2020) in a bid to strengthen midwifery in four focus areas namely:

- Pre-service and continuing professional development
- Strengthening curricula in management, policy development and leadership
- Inter, intra-professional collaborative partnership in and outside the health sector
- Political commitment from major stakeholders.

These focus areas aims at producing competent motivated midwifery workforce within an effective and responsive health system at all levels, midwives to participate in policy decision making and assume leadership roles in relevant levels of the system including research. All this effort can only be more fruitful when based on how the nurses/ midwives and key stakeholders perceive as barriers or facilitators to competent midwifery care in their settings.

Lack of recognition, support and resources and most importantly changes in their roles and identity has impacted on their autonomy are among the barriers to competent midwifery care (3, 4, 5, 6) The level to which the midwives perceive themselves competent and able to access essential resources that enable them to work to full Scope of practice and provide quality of care is the needed measure of their empowerment. (7, 8). Little is known regarding the midwives perspective of the barriers and facilitators of competent or quality maternal health care. The provider's perspective is essential to identify increased impact interventions that may address poor quality services. (9)

PURPOSE OF THE STUDY

The purpose of the study was to explore the barriers and facilitators of competent midwifery practice in rural Zimbabwe from the provider's perspective. The findings of the study contributed in the development of a Scope of practice framework for competent midwifery practice.

METHODS

A descriptive qualitative design was utilised to get an in depth understanding of the provider's perception of their SOP with regard to facilitating competent midwifery practice as well as exploring the perceived barriers to provision of competent midwifery practice in rural Zimbabwe.

Data was collected through four focus group discussions and four key informant interviews conducted between February 2017 and September 2017. The study was conducted in Mashonaland East province which is among the top 5 with high maternalmortality rates in Zimbabwe (10).

Permission to conduct the study was obtained from local and national review boards including Medical Research Council of Zimbabwe. Verbal and written consent was also obtained from all participants.

Purposive sampling of nine immediate supervisors for the focus group discussion (FGD) and four key stakeholders was done with the help of local research assistants and managers. This was done to ensure participants who met the required criteria were selected to produce authentic and credible data. The criteria for supervisors included sister's in charge of the units and clinical instructors where as key stakeholders were those leaders of nurses/ midwifery associations, regulatory board

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representatives and MOHCC representatives with midwifery background and experience of not less than two years.

Sample size was determined by data saturation. FGDs and interviews were conducted at different sites and in privacy guided by a semi structured interview guide. All interviews and discussions were audio-recorded to ensure all details were captured for use.

Content analysis as proposed by Granehum U.H and Lundman B, (2004) was utilised. The basic step of data abstraction, creating codes, condensing to sub-themes and the themes was followed during analysis of data from both the FGDs and Key informant interviews. This was done manually with the help of trained research assistance and data verification from the participants at some point. Data was then presented as themes.

FINDINGS

A total of 13 participants presented their views and options. The following table summarises the participant characteristics.

Table 4.1: demographic profile of participants N=13

Variable	Measure	Frequency	percentage
Age	20-30 years	1	7.6
	31-50 years	9	69.2
	Above 50 years	3	23.1
Sex	females	11	84.6
	males	2	15.4
Years of experience	1-5	2	15.4
	Above 5 years	9	69.2
current position	Immediate supervisor	9	69.2
	Key stakeholders representatives	4	30.8
Highest qualification	Bachelor's degree	4	30.8
	Master's degree	3	23.1
	PHD	1	7.6
	diploma	5	38.5

4.2. The themes, subthemes and codes from thesupervisor's perspectives

The themes which emerged from the supervisors and key stakeholders were consolidated together though analysed separately since they were all pointing to the same central themes. The following table summarised the emerging themes, sub-themes and categories.

The supervisor and key stakeholders perceived the environment in which midwives are practising in as not conducive to promote competent midwifery practice. Five themes emerged including lack of collaboration among healthcare providers, poor leadership and advocacy for midwives, unclear ever

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expanding Scope of practice; ineffective communication system and inadequate material resources were also among the barriers to competent midwifery practice. The facilitators which were raised included but not limited to availability of competent midwives, availability of project specific donor funding and an existing midwifery education and regulating system.

Table 4.2 **Barrier and Facilitators to competent midwifery care**

Barriers	Facilitators
Lack of collaborative support Poor leadership and advocacy for midwives Unclear Scope of Practice Inadequate material resources Ineffective communication system Pre and Post service training	Availability of competent midwives Health system management

Theme 1:Collaborative practice.

Midwifery practice is a complex and needs collaborative efforts to ensure quality pregnancy outcomes. This however is not the case for rural providers in Mashonaland east province where the supervisors and key stake holders reported poor collaborative efforts. They revealed that their colleagues do let them down on provision of quality as they do not respond timeously if called in emergencies they look down upon others and shift the blame to midwives when things go wrong the respondents perceive the environment intimidating where others cannot be confronted for their actions leaving the providers helpless and demoted. The respondents had this to say when asked about collaboration between midwives, doctors and other health workers, "

> *"Our colleagues --- they do let us down even when you want to practice within our sop. If called for emergencies they don't come, we do document but when it comes to auditing they panel beat them and it shifts back to the nurse since they are the bosses in all institutions"* ***(S#8)***

> *"A midwife can encounter a complication but cannot decide what to do without a 2nd opinion of a doctor. This poses serious delays and lead to loss of lives. With a clearly defined SOP it will give a lee way to make decisions since they are independent practitioners." (**KI#3**)*

The issue of collaboration among the health care givers raised emotions among the supervisors and key informants. Some perceive it good while some say it's bad as its favorable to those not close to the shop front as they do not see hoe the midwife suffer with their patients. The following quote expresses those sentiments,

> *"…midwives go long way alone through the hierarchies while the patient suffers in their hands. They call from one person to the other and in most cases to no avail that's why we are advocating for system change.(s#6)*

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> *"I personally think that the co-workers are quiet aware of the sop but aaah…. The problem is whenever something happen like a death which needs an audit. When the problem lies with the doctors it is not pointed out yet it has an impact on the maternal outcomes. Aaah I feel it's bad but I think that's all I can say". (*S#4)

On the other hand another respondent has this to say about the relationship between doctors, nurses and midwives.

> "*I want to say it's a commendable relationship of doctors in the district and nurses' .why l am saying so is because l was in the DHE, where even the midwife has a mandate to transfer if she sees that there is need?*
> *-Drs Out there are not rigid and need they sit and say what do we do to with this Patient and do we go for C/S or transfer.*
> *Even the clinics call the district for transport and transfer is expedited*. (KI#2)

On being asked whether they respect the midwives opinion, the respondent had this to say,

> *"---yes they do respect each other it is reciprocal. It's a 2 way traffic midwives of respecting the doctors and vice versa that's the order of the day." (KI#2)*

Theme 2: leadership, support and advocacy

The participants when asked how as leaders they are supporting the midwives and advocating for a conducive environment which facilitates competence development, they highlighted the lack of a proper forum to discuss such issues impacting on quality of care. They acknowledged that the practice environment is harsh and non-conducive for competent care to be provided. They sighted challenges such as poor communication system, fear of a sour relationship with the superiors, burnout and lack of autonomy of the managers themselves. The following quotes express their views:

> *"---actually I would like to say yes as the immediate supervisor's we do support them. The challenge is there is no proper forum to discuss these issues. We do not have open communication among ourselves at different management levels. Each one is concerned with their own tensions and burnout rather than making the environment conducive for open discussion" (S#2)*

> *"---round table might not be appreciated to some of us not convincing and failing to advocate for the patients or midwives for fear of losing favour from our supervisors above".(S#3)*

> *"--- the nursing managers might be overpowered because representation is not balanced in these executive boards. There is need to revisit the composition to put it back on track since nurses are the majority" (S#4)*

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"I think the matrons going upwards also lack autonomy, they need to be empowered to make critical decisions regarding patient care" (S#5)

On legal protection for the shop floor midwives since the supervisors has acknowledged the harsh environment and helplessness of the midwife it times of crises the respondents has this to say;

,"in actual fact nothing is there. They always say document everything but this has been edited in many circumstances to protect some other individuals leaving others mostly midwives vulnerable. (S#2)

*"As of now the midwife is subject to abuse by other disciplines as anyone can come and tell you do this and since there is nowhere were its written what to do and what not to do." (**KI#3**)*

Theme 3: Scope of practice

The practice parameters need to be clearly defined for one to practice to their full potential. The present scenario is said to be not clear for the service providers, supervisor and some key stakeholders. Respondents perceived the practice parameter should be defined by one's competence and legal restrictions as there are issues of litigation. Some expressed that fear of litigation may result in loss of confidence and even skills from not practicing to full potential. Some feel that task not in line with the remuneration is always shifted to the midwife since it's not clear where they end.

*"...there is more work loaded to the nurse with no recognition in terms of remuneration."**(S#2)***

"---yes you are right on task shifting. For example HIV testing was supposed to be done by lab but now done by nurses and midwives but lab people get allowances and nurses are not recognized." (S#3)

*"---the issue is with the donors, as we are poor when they come they dictate what they want and train more. Three quarters of their activities in the institutions are done by nurses and are funded we cannot refuse it". (S#5**)***

Theme4: Material and human resource shortages

Competent midwifery was said to be hindered by shortages of essential material resources as well as an inadequately staffed work environment. The reality of the matter was that even if the midwives are competent they have nothing to use most of the time. The situation can be disheartening for the poor midwife and usually overwhelmed with no time or anyone to share with. They are said to know what to do but access to resources are limited. The respondents had this to say:

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> ***"…****midwives who are practicing? I think they are aware of their SOP and are doing very well but the challenge is the availability of resources. For example they know that the midwife can prescribe and administer Pethidine without consulting a doctor (laughs) but sometimes the Pethidine is not available for long time or the antidote is not there so much that overtime one loses the competence and confidence to do it. The knowledge will be lost if you have not been practicing for so many years. I have been a midwife for the past 8years but the last time I gave Pethidine was at school so if I am to give it now I have to read about it or ask someone to do it since I no longer feel competent. I think it's one of the things that affect competence development for those in practice" (S#4)*

> *"...the midwife is always faced with challenges of resources even simple basic equipment like heater in nursery and a scale in maternity. I don't know what can be done" (S#7)*

Theme 5: Pre and post service midwifery training and mentoring

The other barrier which was highlighted was the shortage of adequately prepared educators and mentors to facilitate competent midwifery practice. Some respondents attribute poor quality of care to poor pre-service education the midwives receive. Competence based training was cited as the probable solution to curb the high maternal mortality hence the need to strengthen the education system. Participants made the following comments:

> *"The problem with competence based midwifery education is thatthe midwifery educators did not receive the orientation into competence based teaching and learning methodologies*

> *Most of the midwifery educators who have a first-degree in nursing science with a major in nursing education are teaching in midwifery schools yet they did not specialize in teaching midwifery and some of them have limited clinical practice and they are not able to demonstrate the required skills to the student midwives, thus there is a skill gap among the qualified midwives" (KI#4)*

When the respondents were asked about the in-service and continuing education such as BEMONC training whether they make a difference. The respondents had this to say:

> *"...we are many we can't all be trained and it won't be the same if you receive feedback and to be actually involved in the training. I attended it once and I experienced challenges in mastering it for myself let alone coming and trying to teach others back home. Maybe, if it starts with supervisors and cascade down to the hands on and if possible on job training for all practicing will be better"(S#1)*

> *"It's critical that if something is included in the SOP it should be included in the curriculum and assessed competence. It should easily translate to clinical practice. It creates a theory practice gap" (KI#3)*

Facilitators of competence midwifery practice

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Despite the many challenges perceived as barriers to competence midwifery practice, some facilitators were raised by the supervisors and key stakeholders. The facilitators included the provision of supportive environment for available competent midwives and strengthening existing health system management.

Theme 1: Competent and committed midwives

The supervisors perceived the situation was at least not as helpless as it looks as they perceive the midwives competent. They described how the midwives work in the clinical area regardless of poor recognition and support from the other colleagues. They felt the provision of the supportive environment to these already existing competent and committed workforces facilitates competent practice. The following quotes summarize this theme:

"...midwives who are practicing? I think they are aware of their SOP and are doing very well but the challenge is the availability of resources. For example they know that the midwife can prescribe and administer Pethidine without consulting a doctor (laughs) but sometimes they lack resources" (s#4)

"the midwife is competent what needs to be looked at is the legal SOP to be expanded to encompass the issues coming aboard" (KI#2)

Sub-theme 2: Health service management system

The existence of health service management system was perceived as a facilitator for competent midwifery practice. Almost all respondents except a few key stakeholders mentioned the need for health system management strengthening to facilitate competent midwifery practice and in turn improve quality of care. Some of the categories highlighted needing strengthening includes resource mobilization, prioritizing and equitable distribution of available resources, midwifery recognition and empowerment and promoting accountability of all team players. They mentioned that if the little available resources and donor funds could be channeled for patient use it can go a long way in improving quality of care and save them from adverse outcomes. This was echoed from the following quotes,

"the allocation of resources which affect how the midwives practice should be given to people with patients at heart or with a nursing background who understands what it means to see someone dying due to lack of basic resources like blood and intravenous fluids or even a vehicle to transport a woman with complications to next level not the people from the street who channels all money to fuel admin vehicles for their personalized use. They priorities other things other than those for direct patient care like food, drugs and blood and fluids for transfusion yet most donors support hospitals with funds for patient care like RBF but patients are left without food and the basics for their wellbeing except a helpless midwife to their service" (S#6)

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"Plans are made yearly but no implementation and monitoring of resources is done, as well as poor prioritization as my colleagues mentioned earlier" (S#7)

When asked what then can be done to improve the situation? They had the following recommendations to make:

"… that's why we are advocating for system change" (S#6)

"… the nursing managers might be overpowered because representation is not balanced in these executive boards. There is need to revisit the composition to put it back on track since nurses are the majority" (S#4)

On empowerment of the midwife to facilitate competent practice, they feel strengthening midwifery education is needed both pre and in-service. Some felt they are already competent they need support from the powers to be and given autonomy to practice to full potential with adequate supervision and mentoring. The following quotes from some of the participants highlights what can be done;

> *"Midwives and nurses should have access to advanced education and diversify to finance and administration to have equal opportunities for the posts. (S#2)*
>
> *"… giving mentorship in CBE teaching and learning methodologies to midwifery educators and preceptors.*
>
> *"…there is need for motivating the midwife in terms of remuneration, recognition and support" (S#3)*

DISCUSSION

The study identified 5 themes under barriers and two themes under the facilitators to competent midwifery practice. These are not unique to this study as they were identified in previous studies though in different settings. These were discussed below.

Collaborative Practice

Collaborative practice is known to facilitate awareness and appreciation of interprofessional roles. (11), other studies supported the importance of teamwork in attainingquality patient outcomes and provider satisfaction than working in isolation (12:13) Lack of collaboration in health care was said to cause redundant procedures, miscommunication and lack of co-ordinated care (14). Similarly in this study lack of professional collaboration was said to be the major hindrance to competent midwifery practice and lead to loss of mothers and their unborn or new born children. The national research council in 2001 and WHO in 2010 postulated that when emphasis is put on effective communication, collaboration and teamwork the values would surpass current focus on. There is need for unity of purpose for the benefit of the patient and the midwifery care provider.

Leadership, support and advocacy

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Management recognition and effective leadership contributes to staff motivation more than the monetary incentives. This has been seen to improve staff performance to expect standards (15; 16) leaders are expected to provide support and guidance to those being lead thus advocating for their welfare. Failure to do so as was found out from the interview was found to be detrimental to the midwives, the patient and health delivery system at large. Situations which were found to contribute to poor leadership, support and advocacy were lack of laws or code of ethics, lack of support for the leaders themselves and in some case fear of losing favour.(17, 18,19). This was consistent with findings from this study which revealed that the supervisors cannotpoint out mistakes for fear of losing favour from their bosses and the SOP is silent on issues of legal protection. The supervisors voiced lack of support from their superiors so it's a dead end. There is however clear evidence from several studies that supportive and effective leadership creates a climate that is associated with competent health care and excellent patient outcomes. (18-24)

Practice parameters (SOP)

The study findings revealed that unclear practice parameters attribute to fear of litigation, role confusion and increased vulnerability to abuse in the form of task shifting. Several changes in roles of midwives are said to contribute to this role overlap and lead to role confusion. (3, 4, 5) All this coupled with poor remuneration has been cited as barriers to competent midwifery practice. This is common in health care practice as highlighted in many other studies (25; 5, 26, 27, 28) A clearly defined scope of practice has been proven to promote confidence and competence among professionals. (5)

Material and human resources

Inadequate resources were reported as one of the major barrier to provision of competent midwifery care across all settings. This ranged from basic and essential equipment such as thermometers, sphigmanometers to drugs and intravenous fluids for basic resuscitation of patients in times of emergencies. Stakeholders lamented the shortages as even the competent midwives cannot help the mothers. The scenario is not peculiar to the study setting only as several studies reported the same in different settings

Midwifery education and mentoring for competence development

The study revealed mixed feeling regarding midwifery competences as some felt they are already competent while others feel the pre and post service training needs strengthening. Midwifery education in many countries has been found not adequately preparing midwives for clinical practice (29, 30,31,32,33) This however was supported by Benner P. postulation that a sound educational base coupled with multitude of experiences makes a midwife competent or become an expert. The need for mentoring in the clinical area from competent educators and supervisors thus becomes critical. The introduction of competence based education was seen as a facilitator to competent midwifery(33,34,35,) though in the study a gap still exist as the educators themselves were said to be inadequately trained to utilise the approach.

CONCLUSION

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The provision of competent midwifery in the Zimbabwean set-up was met with several barriers as perceived by the supervisors and midwifery key stakeholders. This however is common in many health care delivery settings and these ranged from professional relationships, leadership issues, and inadequacy of resources to mention a few of the challenges. However in the face of the challenges the future was said to be bright as the existence of competent, committed workforce and strengthening of health system management was perceived as facilitators to competent midwifery practice and a light to the dark tunnel.

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