'Going off track': The consequences of barriers to Ghanaian midwives' ability to provide quality care.

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Abstract

Despite global efforts to reduce maternal and neonatal mortality rates, the problem continues to persist, especially in Lower- and Middle-Income Countries like Ghana. For years it has been acknowledged that the deployment of well-trained and regulated midwives could provide a cost-efficient way of reducing maternal and neonatal mortality. However, multiple factors including; recently increasing demands made by birthing women, the growing complexity of midwifery work and a shortage of midwives as well as other barriers have affected the ability of midwives to provide quality maternal and neonatal care. This study aims to provide insight into some of the consequences of these barriers that midwives face in their workplaces.

Methods

Glaserian Grounded Theory was applied in this study. Semi structured interviews were conducted with twenty-nine (29) midwives and four (4) other workers whose roles impacts on the work of midwives. In accordance with the requirements of grounded theory, data collection and analysis occurred concurrently while building on the data that has already been analyzed. Constant comparison was used throughout the data analysis.

Results

The analysis of the data indicated that barriers to midwives' ability to provide quality care have physiological, psychological and socioeconomic consequences on midwives thereby affecting the quality of the care that they offer to women and newborns.

Conclusion

The effects of the barriers to midwives' abilities to provide quality care are intertwined and have consequences on both the midwives as well as on the quality of the care that they provide to patients. By implementing measures to ameliorate or mitigate the effects of the barriers that midwives face in their work, the quality of the care that they provide to women and neonates will be enhanced, which in turn will positively affect the retention of midwives and maximize the benefits of implementing the midwifery model of care.

Background

Years after the end of the United Nations Millennium Development Goal initiative which focused among other targets, on the reduction of high global maternal and child mortality, the issue of high maternal and neonatal mortality still persist especially in Lower and Middle Income Countries (LMIC) (1). It is estimated that women in sub-Saharan Africa have a 100-fold risk of dying due to pregnancy and childbirth compared to those in high-income countries. LMICs also have higher neonatal mortality ratios (2). Like most sub-Saharan African countries, Ghana's maternal and neonatal mortality rates of 310 deaths per

100,000 births and 25 deaths per 1000 births, respectively are both high, even though there has been an increase in recent years in the number of women who access skilled attendance at birth (3–5).

The persistence of high maternal and neonatal mortality in LMICs has been largely attributed to low-quality care in these settings (6). With the shortage of health human resources in LMICs, the provision of skilled attendance by well-educated and regulated midwives is seen as an efficient cost cutting measure because midwives are able to perform most of the evidence-based practices that ensure positive outcomes for maternal and neonatal health (7–9). The midwifery model of care is also believed to have positive effects on general health, education and economic empowerment (10). Midwives are however, faced with a myriad of professional, social and economic challenges that have negatively impacted on their ability to provide quality care to women and newborns (8, 11, 12).

The recent increasing demands on midwives as a result of an increase in the complexity of their work, coupled with shortages of personnel, have resulted in significantly high pressure on them as a professional group (13, 14). Midwives' heavy workload and long working hours have been proposed as causes of extreme exhaustion and fatigue and other physiological consequences (8). Studies in some LMICs have also reported that midwives experience physical attacks in the course of their work (11, 15). Further, it has been identified that midwives face medical issues, including the risk of acquiring nosocomial infections in the course of their work due to lack or inadequate use of personal protective equipment (16).

Psychologically, midwives face a huge work-related emotional burden including that of dealing with the contradictory feelings of fear, anxiety, anger and sadness that come with medical emergencies as well as the excitement and happiness that they feel during the safe birth of healthy babies (17–19). Other psychological consequences of barriers to midwives' ability to provide quality care include constant stress, desperation, insecurity, anxiety and demotivation (15, 20). Midwives' anxiety is believed to sometimes engender panic attacks (21). Members of the profession have also been found to exhibit depression and symptoms of post-traumatic stress disorder as a consequence of dealing with traumatic events (17, 22).

Further, midwives who work in small communities have been found to experience sadness and fear of recriminations when they experience negative outcomes (23). Heavy workloads and challenging working conditions in the face of lack of support from leaders, and low appreciation have also been reported to cause midwives demotivation and depersonalization (24). Midwives' mental and emotional wellbeing has been found to have a reverse impact on the quality of care that they provide. For example, the heavy workload that midwives have to deal with, result in frustration which leads to poor client relations (25). In a review of the literature on factors that affect midwife's ability to provide care to the standard they would like to, Filby, McConville & Portela (11) theorized that being unable to deliver quality care causes them moral distress and burnout, which is characterized by feelings of guilt, anger, depersonalization and demoralization.

The social effect of the barriers that midwives face in relation to doing what they perceive to be a good job reportedly include de-stabilization of their marriages, isolation from the communities that they work in, and the breaking of their social networks because of the requirement to work away from their original communities of abode (11, 15). Economically, midwives in LMICs are often faced with the burden of using their own money in the process of caring for women who cannot pay for various services in order to prevent negative outcomes (11). Studies in Ghana by Banchani and Tenkorang (16) and in other LMICs have reported that due to their heavy workload, midwives are unhappy with their wage (16, 26, 27).

In Ghana, Lohela, Nesbit, Manu et al. (28), have indicated that, apart from medical doctors, midwives are the most capable professionals at providing sufficient quality emergency obstetric and neonatal care. Midwifery-led care is well known now to be beneficial for both women and midwives (10), and Ghana is in the process of implementing the midwifery model of care (29). It is therefore now more urgent than ever to understand organizational barriers to quality care faced by midwives in Ghana, as well as the personal impact of these barriers on midwives' health and wellbeing, so that efforts to implement midwifery model of care have every chance of success. The study reported in this paper brings forth insights into both the barriers to Ghanaian midwives' provision of quality maternal and newborn care, and the consequences for midwives of those barriers. The first aspect has been reported elsewhere (12). In this paper, the social, psychological and emotional consequences for midwives of working in environments that pose so many challenges to giving 'good' care are shared.

Methodology And Methods

Glaserian, or Classic, Grounded Theory methodology was used in this study (30). The study was conducted in the Greater Accra Region of Ghana from mid-January to mid-August 2018. Data collection took place in 10 purposefully selected public hospitals from seven districts as follows: four health facilities from metropolitan areas, three facilities from peri-urban areas and 3 facilities from rural areas. The study sample included 33 participants, 29 of whom were employed as midwives in various positions. The remainder were in non-midwifery positions that had influence over or worked in association with midwives.

Two forms of data were collected including participant interviews, and non – participant observations. Interviews were transcribed verbatim and then analyzed to develop a number of sub-categories, categories and contextual factors that, when all considered together, describe and explain midwives' experiences and behaviors in relation to their ability to provide quality maternity care. A detailed description of the methodology and methods used for this study are provided in a previous publication (12).

Ethical consideration.

The study received approval from both the Human Research Ethics Committee of Edith Cowan University, Australia, as well as the Ethical Board of the Ghana Health Service. The aims of the study were explained to the participants after which they were issued with information sheets giving full details of the research.

All participants agreed to participate in the study by signing consent forms. The participants agreed for the result of the data to be published. The researcher arranged with a trained counsellor to provide counselling to the participant in case the participants needed it, however none of the participants needed counselling. The names used in the findings section are pseudonyms and as such are not the real names of the study participants.

Results

The barriers to providing quality maternity care were found to have significant physiological, psychological and socioeconomic consequences on Ghanaian midwives. These in turn, constrain on their inability to provide quality care. The overarching category in which the data representing the consequences for midwives of working with myriad barriers to quality care was labelled 'I go off track', and this comprises three subcategories, titled: 'It's exhausting and fatiguing; it stresses me out', 'It's frustrating; it makes us angry and we get off track', and 'It affects my household'.

It's exhausting and fatiguing; it stresses me out: The participants in this study indicated that the challenges they faced in relation to their profession and to their desire to provide quality care left them feeling overwhelmingly weary and tense. As well as the exhaustion and fatigue from their work, according to Kafui, a participant, they experience *"mental stress"*. Participants also described how their stress at times engendered a state of distress.

The midwives indicated that, because they take care of women through the whole childbearing episode, it is necessary that they stay close to the women for long periods of time in order to be able to monitor them throughout the birth stages. The high number of women that midwives take care of coupled with chronic staff shortages mean that their workload is extremely demanding. As indicated by Akwele, *"there is always a lot at hand"*. Adding to their high workload and the related stress is the lack of or broken-down equipment, which means they must go back and forth to other units to borrow essential equipment and look for supplies, making the whole process a struggle. This, the midwives indicate, leaves them exhausted by the time they finish their shifts. Asibi, like many of the study midwives, said:

"Because of the pressure, I feel very tired, especially when I get home. Toward dawn, I feel so tired. But I have to come to work. It is not easy".

The midwives also indicated that because they stand or bend for long periods of time to support birthing women, they have back pain as a result of poor manual handling. The poor conditions of birthing couches and the need to transfer clients from one surface to another without the right equipment were cited by the midwives as the cause of their injuries. In most cases, the cost of treatment for workplace injury is borne by the midwives. Fafa provided an example: *'I am having spondylosis, they referred me from here to [the referral hospital]. I take treatment at my own expense. Nobody cares.'*

As well as the risk of injury, the respondents perceived that the high workload and long working hours affected their physical health more generally, thereby causing frequent requests for time off. This is

reportedly compounded by the midwives' inability to utilize their breaks to attend to their nutritional needs because of the demands of the work, Selasie intimated thus: *"The stress can make you lose your appetite for dinner"* and a number of respondents speculated that they have acquired health conditions as a result. Asibi gave an example:

I have developed [an] ulcer because of the work. At times we say it is a wrong profession but we are in it. What can we do? We don't have time for ourselves at all. We always look tired and sick. Always you have body pains and waist pains. Some [of us] are consulting physiotherapists here because of lifting of cases.

Selasie went on to explain that back injuries often occur in emergencies: *"When she [the woman] is bleeding you become restless, you just want to save the client."*

The midwives also indicated that because of the heavy workload on the labour wards, they often stay longer than their working hours. Additionally, demands are placed on them especially when they have staff shortages and when colleagues are late in reporting to work. The consequence of this for many is that, due to the long distances between midwives' workplace and their home, and also because of the fact that they do not have their own means of transport, as indicated by Nakie, *"going back home is a problem"*. Participants indicated that they get to their homes late in the night, especially when they are on the afternoon shift. This then impacts their ability to get to work on time the next day, thus compounding the problem. Further, some midwives feared or actually reported being attacked by thieves in the night when returning home from work. The experience or thought of this was so stressful that, as Khadija explains, she and some of her colleagues had made the difficult choice not to return to their homes and family when they work late because of the threats to their wellbeing and safety:

If your house is far and you are staying [working longer hours], you have to sleep here and go home the following day, because of the fear that you will be attacked. They [thieves] attacked some of my midwives from this hospital and collected their phones from them.

As well as the threat of attack outside of the hospital, the respondents also reported experiencing verbal attacks as well as threats of physical attacks by women, women's relatives and members of the community when those involved perceive negative outcomes to be the result of negligence by midwives. Dela sheds more light on this issue in the statement below:

"A woman gave birth [while] I was on shift... The baby's cord, there are times you have it straight and there are times that you have it coiled like macaroni. The lady was delivered [safely] and went home. In the night we heard some young men hitting the door with stones and sticks. We were like what is it? and they were like their sister said she delivered the baby with a rosary and the midwife has taken the rosary home. I could not help it so I started laughing. Me laughing made them even more upset..."

Further, adding to the participants' stress was the fact that they face infection risks every day due to the lack of or broken-down autoclaves and shortage of personal protective equipment (PPE). According to

Elsie, there is also always the fear that they will, *“transfer the infection to the woman”*. The respondents indicated that due to frequent shortage of supplies such as surgical gloves, masks, gowns etc., they are forced to perform procedures without the right personal protective equipment. Midwives mentioned using examination gloves instead of surgical gloves, using short gloves instead of long gloves or doing mouth-to-mouth to resuscitate babies of unknown infection status because of the absence of ambubags. Elsie gives an example of the risks posed to her and others due to insufficient infection control supplies and equipment:

For some of the procedures, you need an elbow glove, maybe to go into the uterus for examination, but we only have the surgical ones which are short. You end up bringing your hand out and your whole arm is bloody. With this hepatitis, HIV and syphilis, you do it and you run to put your hand in the bleach. You remove it, wash your hands and use sanitizer too, hoping that all will be well.

The respondents also indicated that because there are too few instrument sets for the high number of births that occur, in settings where autoclaves do not always work, midwives must sterilize the equipment with bleach instead of autoclaving so that they can use them again immediately. This exposes the midwives, the women and neonates to infections. Mansah explains why midwives do this below:

We have 10 birthing packs. We can do many deliveries and it will get finished. So when we put it into the bleach for 10 minutes and we wash it and put it in another one for 5 minutes then we use it for them (women and neonates). We cannot say that because we have used up all our instruments women should go to another facility.

What reportedly made participants' stress and fatigue worse was the perception that management often did not support them when things went wrong, as indicated by Sika: *“The health worker is not their [management] priority, it is the patient [that is their priority]”*. The respondents indicated that even though other factors such as the lack of resources especially equipment may be the cause of the outcome, midwives perceive management to always be on the side of the clients. As Mercy, whose views form part of this subcategory label, also said:

Whatever you have, you use it. It stresses me out. I get tired. Like yesterday the baby was dying. You don't have suction machine. At the end of the day too, they [the baby's parents and the management] will put the blame on you. I get anxious.

Even in the face of seeming lack of support from management, midwives showed a great sense of responsibility in their work due to a general acknowledgement among the respondents that their care impacts not only on the birthing woman and the neonate but also the woman's family. Elie captured this view in the following statement: *“You are not only dealing with mother [woman]; you are not only dealing with child [newborn]. You are dealing with the whole family. Mother is here but children are in the house waiting for mother, husband is in the house waiting for mother even grandmother is depending on mother so you are dealing with the whole family. Should something go wrong the whole family is affected.*

Although this huge sense of responsibility shown by midwives is a source of motivation, it is also indicated by midwives as a source of pressure on them given the barriers that they face at work.

As well as the stressors noted above, other aspects of the job confer additional stress on midwives that give rise to emotional tension. One significant factor mentioned by many of the participants was that, because of infrastructural constraints, midwives do not have equipment and other resources to care for women or newborns who need Intensive Care Unit (ICU) or Neonatal Intensive Care Unit (NICU)-level care. Because of this, midwives have to refer and transfer most emergency cases to other health care sites. Because most of the facilities do not have their own ambulances, delays in getting ambulances or other transport to convey clients to referral facilities, as well as getting referral facilities to accept referred patients, were mentioned by midwives as a major source of stress and anxiety. Margaret, like others, described a typical emergency transfer scenario:

You are now going to put the person into a car and send the person to [another hospital]. When you get to [the other hospital], [they] will say the place is full, you go to [a different hospital], [that hospital] says it is full and you are the midwife in the car. Your heart will be pounding. You will get anxious.

Another cause of midwives' anxiety is the uncertainty of getting the required drugs and supplies to use when needed. Participants indicated that although the hospital pharmacies stock most of the drugs needed for the care of women and neonates, sometimes there are shortages of emergency drugs and supplies, meaning, the midwives do not always get the emergency drugs they need to treat a woman on time, especially during emergencies because clients' relatives have to go outside the health facilities to buy the drugs at pharmacies. Expatiating on the issue, Ayele pondered, *"So if someone does not provide it [drug] when labour starts what do you do?"* As well as birth sets, elbow gloves and ambubags, shortages of supplies such as surgical gloves, sutures, syringes, and transfusion sets for babies was also mentioned by midwives as a source of stress. Kafui summarizes it thus:

There is also mental stress. I think too much. When I want to do something, I get confused. I don't know what to do. Maybe you come to work you need drugs, you need syringes, and these are not available and you still have to work. You have to go about looking for some, if you don't get, you manage with what you have.

Unreliable patient history was also mentioned by midwives as a cause of anxiety and stress in the workplace. In some cases, women either intentionally or unintentionally provide inaccurate medical history. Respondents indicated that often, women who had not attended antenatal appointments would suddenly report to the labor ward without midwives knowing their medical or obstetric history. The respondents indicated that the absence of or inaccurate health information was a source of stress and anxiety, because it seriously impacted their bid to provide quality care to women and neonates. Amina explain this further:

It causes anxiety. If a scan has been done and everything is clear, it is easy. But if the person has not done all the tests, no scan, you still have to manage her because if you don't manage her, she will go back to

the house. Anything can happen to her.

It's frustrating; it makes us angry and we get off track: The midwives in the study indicated that they get frustrated when they do not get the required input to help women and neonates. This situation is complicated when delays in the process of care occur as a result of the unavailability of resources such as drugs or equipment, and when infrastructural issues result in low quality care or maternal or neonatal deaths. The hostile environment in which clinical audits are conducted was also mentioned by midwives as a cause of their frustration. The participants also indicated that high levels of frustration sometimes result in anger, and some disclosed that their anger sometimes affects how they interact with women. Asibi, like other participants, spoke frankly about how their working conditions can impact on women in their care:

When you have a lot of people or when you are under pressure, you tend to vent out that frustration on patients and you end up talking to them anyhow. People take it like midwives are rude but sometimes you have to be in this situation to know what it takes. We try.

Predominantly though, the midwives indicated directing their anger towards their managers, immediate supervisors and colleagues from other departments when they perceive that management or other health personnel are not doing enough to help them get the needed resources to help in their work. As Buruwah said, *'We report to the appropriate quarters but if nothing is done what will you do? At the individual level, I get angry, I report [to my superiors].* Those to whom she reports the problems are, she says, in highly influential positions, but, like others, Buruwah went on to say that even when she gets angry and confronts her superiors, *'they don't say anything... We don't see any effect. Nothing is implemented, so you talk and talk and talk but nothing happens.'*

The result of midwives' frustration and anger, and of them having to constantly demand the things that they need for a long period of time before they are provided, or the failure of management to provide the needed resources, causes them demotivation. According to the participants, the feeling of demotivation is even higher when there are poor maternal or newborn outcomes because they feel that if they'd had the full complement of the equipment needed to provide optimal care, the outcome may have been different. In a quote from Mariama, she described the demotivation she felt as a result of all the challenges she experienced at work, and their impact on her, as 'going off track': *'...it puts me off. Maybe I need something to do my work and it is not there. Maybe for a while I may go off track just because I don't have what I actually need.'*

Finally, compounding participants' frustration and anger, and sending them 'off track' is the ever present spectre of clinical audit which, according to the respondents, is highly emotionally challenging. When a mother or a neonate dies intrapartum, the midwife who provided care must attend a maternal or neonatal audit meeting (known in other contexts as Root Cause Analysis meetings) to explain what happened. As indicated by Asibi, at this meeting, *"they make you [feel] useless, as if you don't know your left from your right."* The midwives indicated that the audit process causes them a great deal of frustration because they cannot always pinpoint exactly what they could have done about the negative outcome due to the

unavailability of resources. Akwele further explains the confusion and its impact for midwives in this scenario below, and in her quote, the need for and absence of any emotional support for midwives in this situation is evident:

When you care for somebody and unfortunately the person goes off (dies), the kind of thinking that you the midwife you will go through... It is not only because you will be going for auditing and they will be asking you a lot of questions, but you will ask yourself what went wrong. You were trying to do your possible best and at the end of the day you did not know what went wrong. It has happened to me before. I did not sleep. I sat for the whole night for about 2 days. I was stressed out because I was trying my best but...

It affects my household, my friendships and my community standing

Earlier, some of the impact on midwives' households, friendships and community standing of the work-related challenges they face were reported: because of the constant heavy workload and their long working hours, the participants indicated that they are always exhausted by the time they get home after their shifts. This, coupled with the demands of the work such as having to work on weekends and on holidays, makes it seem to participants that they are always at work, as the following quote by Akos indicates: *"All the time I am here [at the facility]"*. This, according to all respondents, makes it difficult for them to spend quality time with their family. Ashokor, went so far as to say that, *"Once you are here, you cannot have family life"*. This seemed to be particularly difficult for those who have school going children, as Asibi suggests: *"They [her children] hardly see me at home"*. Participants also indicated that the constant exhaustion as a result of the high workload makes it difficult for them to complete their household chores. Clara indicated in a quote that:

By the time you finish your work and the documentation you will be exhausted. When you go home, you have to pick [up] your children and do other things. I do not get enough time for my husband and children.

The high workload on the labour ward also reportedly affects breastfeeding midwives, who are not able to leave to attend to their infants. Even though there is a policy provision for them to do so, they find it difficult to absent themselves when there are many clients and the remaining midwives are not enough to take care of them. As Margaret said,

The young ones too it is affecting them. As somebody who is having a child, they say they should do exclusive breastfeeding but if you see the ward you can't leave ... because if your colleagues are there and they have cases and you see them going up and down, you cannot say you are going.

As well as the implications of working as a midwife in a resource and support-scarce, context outlined earlier, the respondents indicated that shift work and working on weekends, on holidays and other festive occasions affects their marriages. According to the midwives in this study, because of their work schedule, they are unable to join their spouses for celebrations such as weddings and other events or for trips during Christmas, Easter and other holidays. For some newly trained midwives, having to stay apart

from their husbands because of their posting negatively affect their marriages. Elsie went into more detail in the following quote:

Taking transfer from one place to the other, that one, it will take more than six months, at times a year. If your partner is one who cannot hold on to his ego or libido, you will end up going to meet another woman in your matrimonial home, because nobody is there to cook, clean the house or satisfy him emotionally.

Having to work on weekends and public holidays means that midwives are not able to attend most social events, thereby causing their isolation from their larger families and their community. As a result, some are perceived as uninterested or uncommitted community members. Amina explains in the following quote:

To be frank with you, it has been a problem because we Muslims, when you are around [in your community], naming ceremonies, marriage ceremonies, and funerals, you need to be attending, even if not all of them. But because of this work, when something happens I can't go. So people will say that I don't care about anybody."

The midwives that work in rural facilities are also faced with the challenge of not being able to take their annual leave though they often live very far away from their families and friends; this is because of the difficulty of finding relieving midwives to take their place whilst they are on leave. Sika, who is a rural midwife, indicated that she has not been on leave for two years. In explaining the reason why, she indicated: *"I feel that when I leave my client will come and I will not be there."*

The barriers to the midwife's ability to provide quality care also have economic consequences for them personally. Because of their desire to see women and or neonates survive, and also because they do not want shortage-related negative outcomes that they will be held accountable for, midwives reported that they often contribute their own money to buy essential drugs, pay for blood, buy food for women or buy supplies. As indicated by Elsie – *"even if it is the last money on you, you are forced to give it out."* Midwives, especially those in rural areas, are also often burdened with the cost of conveying patients to referral facilities. The respondents indicated that although they get significant number of such cases, it is only on a few occasions that their monies are refunded. Though midwives indicated that they have a strong desire to see the women and their neonates survive, most of the time, they feel they have no choice but to use their own money because of the fear of negative outcomes both for those in their care and themselves as indicated by Tani below:

"The midwives who were on duty had to contribute money to go and buy blood to serve as a standby. The midwives didn't want a situation whereby the woman will go into labour and develop any complications and it will be on them. It is not that they want to give the money. They are forced to because they don't want it [negative clinical outcome] to happen on their shift or even in the unit."

The financial implications brought about for midwives because of their work context include the need to buy family support in their absence. The inability of the respondents to complete their household chores

due to the fatigue from their demanding workload and also because of their long working hours, that causes them to stay away from their children for long periods, midwives reported having to pay nannies to help them with their domestic chores and other activities in their homes because they find it difficult to do them themselves. As an example, Akua described the monetary impact for her family thus:

"I am not able to see my girl [her daughter] for maybe 2 to 3 weeks. I only call and send money. I pay the teacher 70 cedis every week, and at the end of the month I have to pay 150 [Ghana] cedis to her for taking care of my baby."

Discussion

The main aim of this study was to investigate the consequences that barriers to midwives' abilities to provide quality care have on them. Findings from this study indicate that midwives show a great sense of responsibility in their work. There is a general acknowledgement among the midwives that the care that they give affects not only the birthing woman but also on their neonates, the families of the women, as well as their larger society. Our participants indicated that the huge responsibility they are charged with is a source of motivation as well as a source of pressure on them, given the barriers that they face in their work on a daily basis.

Quality midwifery care requires that midwives be with women throughout the birthing process and the puerperium. However, midwives in this study indicated that this is not always possible due to their heavy workloads. The heavy workloads, coupled with the unavailability of essential equipment, cause midwives to be exhausted by the end of their shifts. This finding is similar to the findings in a study in Senegal (31) that indicated that long working hours, heavy workload and challenging working conditions cause midwives extreme exhaustion. Another study in Kenya (26) also indicated that midwives experience high levels of fatigue. Other effects that were indicated by midwives in this study included back and waist pains, injuries, medical conditions such as high blood pressure and stomach ulcer and the risk of acquiring infections at work. Midwives also reported experiencing verbal attacks and threats of physical attacks by clients' families and other community members. Earlier studies have reported that midwives in Uganda and South Africa also face physical attacks in the course of their work (11). Further, the concerns of midwives in the current study about contracting nosocomial infections on their job is corroborated by the findings of Banchani and Tenkorang (16)'s study in northern Ghana.

In our study, midwives were found to be experiencing pressure due to the sense of responsibility that they felt about saving the lives of mothers and newborns and the expectation by women, clients and communities on them to deliver in the mist of unavailable resources. Other sources of pressure include high workload as well as lack of support from facility management. This finding is contextualized by Hunter and Warren (14) and Geraghty, Speelman & Bayes (13), who each conclude that the responsibility to manage the feelings of women and their families is a source of pressure and stress to midwives. The pressure that staff shortage has on midwives has been underscored in other LMIC settings (18, 32). The midwives' anxiety and stress that results from non-availability of the essential necessities of care, as well

as the uncertainty of getting available equipment and other resources to use when needed, is important noting as similar finding in Ghana has indicated the effect of anxiety on the emotional wellbeing of midwives (20). In the afore mentioned study, it was indicated that midwives are also stressed by the uncertainty of getting support from colleagues and physicians. According to the authors, this causes the midwives desperation and insecurity.

The issue of anxiety among midwives is important to note because Spendlove (21) identified that when it occurs as a result of inadequacies on the job, it could cause midwives to have panic attacks. Leinweber and Rowe (22) indicate that midwives have been reported to show symptoms of traumatic stress disorder as a result of dealing with traumatic events. Also, according to Spendlove (21), midwives' anxiety over errors could influence them to adopt defensive practice and thus skew practice towards the biomedical model of care, to the detriment of the midwifery model of care that supports natural birth. Given this finding, the issue of anxiety among midwives should be taken seriously as it has the potential to undermine the midwifery profession in Ghana and other LMICs.

The midwives we interviewed reported that, frustration due to negative outcomes caused by the unavailability of resources, causes them to be frustrated and angry, sometimes at clients as well as at their supervisors and other health workers. They also indicated their frustration to be compounded by the hostile nature of 'bad outcome' audits. This finding is similar to that from a study by Richard, Oudraogo, Zongo et al. (33) in which midwives perceived that audits are 'unfriendly' because of the absence of anonymity and a focus on the negative aspects of the cases. The issue of midwives' anger with clients has been found in other studies to cause high levels of frustration that results in anger and can spill over into poor interaction by midwives towards their clients (26, 34). However, in contrast to the findings by the authors mentioned above, our study identified that midwives predominantly directed their anger at their immediate supervisors and sometimes their colleagues. Previous work by Banchani and Tenkorang (16) also reported the anger that health care workers feel when leaders fail to respond to their pleas for help.

Furthermore, our participants indicated that failure of management to provide essential equipment for work causes them to be demotivated, especially when the unavailability of essential equipment results in negative outcomes. This supports the finding in work by Bremmes, Wiig, Abeid et al. (24), who found out that the lack of support from leaders and low appreciation causes demotivation in midwives, and that of an earlier study by Lavender and Chapple (35) in which midwives were reported to perceive that their immediate supervisors were not doing enough to help improve the difficulties in the course of their work.

Finally, the socioeconomic effects of the barriers to midwives' ability to provide quality care include the effect on the midwives' participation in running their households, their mothering duties, and their personal relationships. Filby, McConville & Portela (11) have stated that working long hours and excessive work-loads affect midwives' domestic roles as well as their relationships because they have been found to cause suspicion of spousal abandonment and infidelity. Social isolation was also a finding in this study, and this too corroborates what Filby and colleagues found in their exploration of what

prevents quality midwifery care in LMICs. Their study presented evidence from studies in Ghana, Nigeria and Niger that mentioned midwives' isolation from the communities in which they work and also the difficulty in starting a family. This finding is worth noting, since midwives in this study mentioned working away from home and having difficulty in taking annual leave as a factor in their isolation from their families and friends.

Economic effects on the midwives in our study were also apparent; many used their own money for medications, other supplies and food for women in order to ensure positive outcomes. Given the findings from studies by Wesson, Hmunime, Viadro et al. (34) and others, such as that by Banchani and Tenkorang (16), wherein midwives reportedly perceived their remuneration as not commensurate with the work that they do, spending their own money on women to ensure positive outcomes is likely to fuel disenchantment, particularly given that Jones, Michael, Butt et al. (27) have identified that midwives perceive that a poor salary gives them a lower status in their communities. This situation may cause attrition because the cost, in literal financial terms, to midwives is too great: Beck and Anderson (36), among others, have considered the emotional cost to midwives of being 'with woman', however direct financial cost to midwives working in LMICs in the course of trying to provide quality has not previously been described.

Conclusions

Midwives are vital for the reduction of maternal and neonatal mortality given the key role that they play in ensuring that women birth safely, especially in LMICs where there is a dire shortage of health personnel. As indicated in this study, although midwives are doing their best in the care of women and neonates, they are faced by myriad barriers that have physiological, psychological, and socioeconomic effects on the midwives and as such on the quality of care that they provide. Each of these effects – physiological psychological or socioeconomic - could have profound effects on the midwives on their own, however, a closer look reveals that the effects are intertwined and reinforce each other. For instance, the physiological effects of exhaustion, injuries and infection risks directly affect the output of the midwives in their working roles, as well as their mothering duties, domestic duties and relationships. Also, the psychological effects of pressure, stress and anxiety have the potential to confer physiological effects on midwives in the form of medical conditions such as post-traumatic stress disorder and consequently on the quality of care that they provide to women and neonates. Although this study did not actually measure burnout and demoralization, some of the effects seem to be pointing to this and further exploratory research is required. Nonetheless, the findings of this study clearly indicate what maternity service leaders and organizers need to consider if they wish to reduce the barriers to quality midwifery care and thereby enhance the retention of midwives in order to maximize the gains of the midwifery model of boosting positive outcomes for women and neonates. Specifically, this includes supporting midwives in the provision of resources as well as ensuring that midwives work in environments which promote supportive management styles that considers their views.

Declarations

Competing interests

The authors would like to hereby declare that we have no competing interests as far as this study is concerned.

Authors' contributions

YI, SB and SG conceived the study design. YI collected all data, and led the data analysis and the writing of the manuscript. SB and SG contributed to the analysis of the data and development of the manuscript. All authors read and approved the manuscript.

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