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# Experiences of Workplace Adversity Among Midwives in Labour Wards of Tertiary Hospitals in Northern Nigeria.

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## Abstract

**Background:** Midwifery has been described as an emotionally charged profession. It can be even more demanding in the face of staff shortages and lack of basic resources often encountered in low- and middle-income countries. The Nigerian context has particular workplace features, including high levels of maternal and infant mortality, shortage of midwifery workforce and a high prevalence of stress among midwives, which justified the conduct of this study so as to understand the impact of workplace adversity on midwives and enhance staff retention.

**Objectives:** The aim of this study was to explore midwives' experiences of workplace adversity and resilience in tertiary hospitals of Northern Nigeria. This article shall present findings relating to characteristics and experiences of workplace adversity among these midwives that led to the development of their resilient responses.

**Methodology:** This study used a constructivist grounded theory approach. Data were collected via interviews and field notes. Ethical approval was granted from all necessary institutions. Thirty-four interviews were conducted in two phases with purposive and theoretical samples of midwives across two tertiary institutions in Northern Nigeria. Data analysis used the iterative process of the grounded theory methodology.

**Results:** Significant adversity was caused by firstly, severe lack of human and material resources leading to excessive workload, and secondly, the nature of the work characterised by high number of obstetric emergencies and attending to traumatic births.

**Conclusions:** Midwives working in tertiary hospitals in Northern Nigeria experience workplace adversity fuelled by high caseloads, workforce shortages, lack of basic equipment and consumables, an unsupportive working atmosphere and attending to traumatic births. More investment in Nigerian maternity services is needed to improve quality of care provision and reduce adversity within the midwifery workforce and so enhance staff retention.

Key words: Midwives, Healthcare professionals, Workplace adversity, Stress, Tertiary hospitals

## **Background**

Several authors have recognised midwifery as an emotionally charged profession, which becomes even more demanding in the face of the shortage of midwifery workforce globally (Hunter and Warren 2014; UNFPA, ICM and WHO, 2021). In common with other delivery suites around the world, the tertiary delivery suite in Nigeria is an unpredictable environment where midwives work closely in teams with other health care professionals. It is also a centre of learning where a range of health care students acquire their clinical experience, including resident doctors on clinical obstetrics and gynaecology training programmes and medical house officers on three-month rotational experience. Workplace adversity is likely to be increased because of frequent staff changes, which can make the unit a very busy and stressful place to work. These all create pressure on the midwives, which may result in stress and ultimately lead to burnout (Ladan et al, 2014).

Typically, the tertiary hospitals have high numbers of maternity cases. The Primary Health Care (PHC) facilities are designed to be the community first point of contact into the formal healthcare system, from where pregnant women with complications are referred to either secondary or tertiary health centres for further management (Ogu et al., 2017). Due to the inadequate functionality of primary health centres throughout Nigeria, most patients reportedly avoid the PHC facilities and self-refer to tertiary care centres (Ogu et al., 2017; Koce et al., 2019). Although private maternity facilities are also available in many parts of the country, their high cost prevents many women from accessing them (Ogu et al; 2017). This may explain the increasing number of women utilising the few existing public secondary and tertiary health facilities for maternal services, resulting in a growing number of women being cared for in the tertiary hospitals, thus increasing the pressure on midwives and potentially contributing to workplace adversity.

## **An Overview of the Literature**

The evidence relating to workplace adversity in maternity care in low- and middle-income countries (LMICs) is limited. Also, some studies reviewed used the terms

'workplace adversity' and 'stress' interchangeably and stress was conflated as workplace adversity, whereas stress is an actual response to workplace adversity. A review of the literature provides insights into the workplace adversity experienced by midwives in LMICs. For example, a shortage of human resources has been reported in the most recent publication of the State of the World's Midwifery (SoWMy), as a source of concern among midwives in approximately 194 countries. The report estimates that there is a global shortage of 900,000 midwives (UNFPA, ICM and WHO, 2021). Shortage of human resources leads to an overwhelming workload and a limited-service delivery quality (Thorsen et al., 2011). This workplace adversity may negatively influence midwives' decision to remain in the profession.

Two quantitative studies have explored workplace stress among health workers in Nigeria, including doctors, nurses and midwives. They provide an insight into the levels of adversity experienced by health workers (Anyebe et al., 2014; Ladan et al., 2014). Findings from these studies concluded that a high incidence of occupational stress-related burnout among nurses and midwives existed. A shortage of staff with many patients to care for, a lack of adequate equipment, long working hours and poor communication with colleagues were identified as some of the major causes of workplace stress. (Anyebe et al., 2014; Ladan et al., 2014). However, there is a lack of qualitative studies into all health care worker's experiences and also a lack of midwifery specific studies to enhance the understanding of the findings.

It is worth noting that midwives are responsible for two lives, that of the mother and her new-born. However, this responsibility becomes more challenging in the Nigerian context of high levels of maternal and infant mortality and shortage of midwifery workforce. Given these pressures, together with the job's unacknowledged emotional demands even in non-emergency situations (Hunter and Warren, 2014), midwives' experience of stress and workplace adversity is likely to be increased. This may further contribute to increased staff ill-health and result in staff shortages which further exacerbates pressure on the remaining midwives. Midwives' shortages combined with harsh work environments characterised by poor power supply and lack of basic commodities appear to make it difficult for midwives to provide quality care to their clients (Bradley et al., 2019). These challenges, together with the

increasing numbers of facility-based births notable in tertiary hospitals, poverty of women and their families and inadequate hospital resources result in a 'perfect storm' thereby creating a sense of adversity for these midwives (Bradley et al., 2019, p.3). Midwives who are stressed are less likely to give good quality safe care to mothers and their babies (ten Hoop-Bender et al., 2014) and thus it is pertinent to find out how best to support the midwives so they, in turn, can better support and care for mothers.

In Nigeria, specifically, evidence suggests that maternity services are facing many challenges, including a shortage of midwifery workforce, lack of adequate facilities and a limited number of midwives graduating each year (Kuforiji, 2017). However, only a few studies have been conducted on the causes of workplace adversity that may result in stress and burnout, and these were with nurses, while none were carried out specifically within the maternity setting. The studies reported high prevalence of occupational stress and emphasised the link between workplace stress and burnout (Anyebe et al., 2014; Ladan et al., 2014). Therefore, in order to better understand the causes of stress, so that remedies can be put in place, causes of workplace adversity need to be explored in-depth, specifically in the maternity care setting in Nigeria and other LMICs. Considering the current shortage and the estimated shortage in the foreseeable future, it is very important to improve the current situation so that Nigerian midwives thrive in their work and their wellbeing. This would aid retention and would assist in achieving the quality maternal services necessary to attain the maternal and child health targets of the United Nation's Sustainable Development Goal 3.

The overall aim of this study was to explore midwives' experiences of workplace adversity and resilience in Northern Nigeria. More specifically, our focus was on experiences of adversity and these can contribute to the development of midwives' resilience.

## **Methodology**

A constructivist grounded theory (CGT) methodology was employed in this study (Charmaz, 2006). CGT is guided by the premise that the creation of knowledge is the joint responsibility of the researcher and the participants (Charmaz, 2006).

### **Population and setting**

The study population was all clinical midwives working in the obstetrics ward in two tertiary hospitals in Northern Nigeria, named hospital A and hospital B, to protect the anonymity of the two research sites. They were two large urban teaching hospitals which recorded 3000 and 3600 births respectively. The total number of midwives working in obstetric units of Hospital A was sixty-seven whilst Hospital B had a total of thirty-five midwives. Midwives who were working in the obstetrics wards at the two tertiary hospitals at the time of data collection and willing to participate were included in the study.

### **Data collection and analysis**

A two-phase study was conducted in two tertiary obstetrics wards over nine months. Phase one was conducted between January to April 2018 while Phase two was conducted between May to August 2018. Purposive sampling was used in the first phase to recruit twenty participants followed by theoretical sampling in Phase two.

For the theoretical sampling, a total of fourteen interviews was conducted with some of the midwives who took part in phase one. The theoretical sample consisted of those midwives who considered themselves as resilient from the initial data analysis, or midwives described as highly resilient by most of the other participants. Midwives representing varying lengths of experience were approached to explore whether length of experience was an important factor in developing resilience. To begin the process of interviewing the theoretical sample, the first midwife described as resilient by participants at both hospitals was approached, they served as a link to other midwives using snowball sampling. Each participant was contacted, and a date was agreed for the interview. During the interview, the midwife was asked to describe any

midwife she considered to be resilient. The midwives described were part of the purposive samples and were further contacted after a consent form had been signed. This process continued until theoretical saturation was achieved.

Semi structured interviews and field notes were used as tools for data collection. The interview guide was designed and was pilot tested on three midwives who were not part of the study to ensure clarity of the question. The interview venue was decided by the participants and was either at their workplaces or at their homes. Each interview was conducted by the first author. The interview process encouraged the participants to discuss matters that were important to them and remained focused on the participant's perspective. The interviews were conducted in the English language and each interview lasted between 60-90 minutes. All the interviews were audio-recorded and transcribed verbatim.

Data were analysed iteratively; this is the process of analysing new data as soon as it has been collected and transcribed so that subsequent collected data can be refined. A span of one week was allowed for analysis and reflection before each new interview. Data analysis commenced with exploring the first interview for underlying meaning using the initial line-by-line coding as a heuristic device (Charmaz, 2014). Data were coded with a label that captured meaning. As analysis progressed, the constant comparative approach was employed, where each coded line of text was constantly compared with other lines of already coded text from different interviews and their corresponding initial codes. A focused coding and theoretical coding were also employed. Focus coding searches for frequent and vital codes from initial codes to develop the most remarkable categories in the data (Saldana, 2016). Theoretical coding explains the data and show relationships between the categories developed through focused coding (Charmaz, 2014). Coding and categorising of interview transcripts was supported by NVivo 12.

### **Trustworthiness**

Data collection and analysis were conducted by the first author and overseen by the supervisory team (BH, LW and DS) who are all experienced qualitative researchers.

All authors read the transcripts to ensure nothing was left out and also to increase the credibility of the analysis. After the transcripts were reviewed using the audio recordings, areas of concern were identified, and ways of probing further were suggested. The transcripts were coded and also categorised by two of the authors again and previously coded transcripts by first author were revised by the fourth author. Reflexivity was useful throughout the process of data collection and analysis to enhance credibility of the findings. Constant comparative analysis was employed to ensure trustworthiness of the data.

### **Ethical considerations**

Ethical approval for the study was secured from Cardiff University's School of Healthcare Sciences Research Ethics Committee and the local ethics committees at the two research sites in Nigeria. Copies of the participant information sheet were distributed to the midwives at their weekly meeting. These contained detailed information about the study, the aim and design of the study, how and why they had been approached, and the time needed to participate. If interested, they contacted the first author by mobile number provided on the participant information sheet and volunteered to participate in the study. Participants were assured of confidentiality and anonymity prior to the start of each interview and informed that they could withdraw their consent at any time. Pseudonyms were utilised throughout the study.

### **Results**

Thirty-four interviews were conducted with purposive and theoretical samples of twenty midwives across the two study sites, between January 2018 – August 2018. Twenty participants took part in phase one and fourteen of them also took part in phase two. The first category '**Experiencing workplace adversity and perceived effects**' describes what created workplace adversity. This category is further divided into two subcategories. Subcategory A, represents the experiences of workplace



adversity whilst Subcategory B, explains participants' responses to and perceived effects of the adversity experienced. Findings are presented using extracts from participant interviews as well as extracts from memo writing and field notes.

**Table. 1: Experiencing workplace adversity and perceived effects.**

	Subcategories	Focused codes
Experiencing workplace adversity and perceived effects	a. Experiences of workplace adversity	1. Working in a difficult workplace environment. 2. Having poor collegial relationship. 3. Having difficult midwife – patient relationship. 4. Attending to a traumatic birth.
	b. Responses to adversity experienced	Being abusive. Delivering poor quality of care.

### **Experiences of workplace adversity**

#### *Working in a difficult workplace environment.*

Most participants felt that working as a midwife was impacted by several factors. These included dealing with a heavy workload and caring for women and babies with complex needs and obstetric emergencies, where women were rushed in late for care, and the midwives were expected to provide care to save the lives of the mothers. The midwives also described working alone as a midwife and an inability to take breaks. These situations created stress. In the following data extract ,Mary describes the difficult conditions in which midwives work. She described having to deal with many obstetric emergencies where women arrived at the hospital when their condition had deteriorated, and the patients' relatives expected the midwives to perform the impossible.

*“Sometimes a case of PPH [Post-partum Haemorrhage] where the woman gave birth at home, the condition will be so bad, and the patient’s relative will be expecting the midwife to perform magic as soon as they arrive”  
(Mary, Hospital B)*

The midwives also described dealing with high patient caseloads as challenging. Aisha explained that with staff shortages and large number of mothers to care for, the midwife becomes so busy that she may sometimes ignore women who are calling for her attention. This was reported as contributing to a midwife’s stress and eventual disengagement.

*Two midwives to like 10, 15, at times 20 women at night! You are taking delivery, monitoring them using partograph, all at the same time. At times the women will be calling you, you will even ignore them and go home, because several people are on your head. (Aisha, Hospital B)*

The midwives also reported that sometimes, with high patient case ratios, it became difficult to provide space to accommodate these women, compromising the standard of care. If most of the bed space was occupied, they were forced to care for women on the floor as described by Mariam. This could result in infections and even trauma to the baby. It is also unpleasant for the women and not respectful or dignified care.

*You know it becomes hectic, like two days ago, we had women having childbirth on the floor because the delivery couches were filled up. It is as bad as that (Mariam, Hospital B).*

Health and health-related resource constraints were widely discussed, and participants referred to these resource constraints as stressful and contributing to a sense of adversity. These included lack of delivery items (consumables and drugs), lack of appropriate birthing beds and lack of power supply which impacts on safety of both mother and baby. Joan reported that neonates sometimes required extra attention after birth and that she then had to call for assistance urgently as the baby’s life was in danger. This was made more difficult by the lack of available resuscitative equipment in the delivery suite. This all adds to work pressure.

*Sometimes oxygen will not be available in the labour wards, we must take the baby to SCBU [special care baby unit] before they can get oxygen, I use to raise alarm to the doctors for help.. (Joan, Hospital A)*

Helen described how a lack of such resources creates more pressure on midwives, this was typical of many accounts. She explained that a lack of power supply may worsen the situation thereby making the work environment unsafe for the midwife and the baby.

*There is no power and you have to climb upwards to take the neonate to the SCBU, you have to shout for the father or any relation to provide a light source... (Helen, Hospital A)*

In addition, many midwives also described how lack of appropriate birthing beds resulted in midwives assuming an awkward posture while attending to birth. They reported that actual birthing beds are ergonomically designed, thereby minimising twisted or bent posture while conducting birth. Joan described how difficult it was working in a delivery suite without the actual birthing beds, she explained that this created trauma to the back.

*Where actual birthing beds are not available, you have to bend down to conduct delivery and then traumatising your back! (Joan, Hospital A).*

These accounts from the midwives were further complicated by difficult relationships at work which is described in the next paragraph.

#### *Having poor collegial relationships*

Poor collegiality was a source of adversity for the midwives. One of the difficulties experienced by most of the junior midwives was the lack of support from some senior midwives. The stories told by the participants suggested poor collegial relations, these included poor teamwork, distrust, gossip, grudges, and harassment. Poor collegiality hindered appropriate and effective interpersonal communication. This resulted in frustration, anger, fear, resentment, exhaustion, and stress that affected participants' wellbeing, and job satisfaction.

Maimuna, a junior midwife reported lack of support from the senior midwives. In her experience, they tended to allocate difficult tasks to the juniors without supervision. This was reported as adding stress to their pressured work and has safety implications.

*Some of the senior midwives will just relax and allow you to do the difficult work without supervision! you will be very tired and exhausted (Maimuna, Hospital B)*

#### *Having difficult midwife – patient relationship*

Interacting with the women's relations could be a source of adversity, as some were described as aggressive and impatient. Binta described how some of the women's relations demanded immediate attention when the woman arrived at the hospital and expected the midwives to suspend whatever care they were providing to other women at that point. She explained that they could become verbally and physically aggressive if not attended to promptly. Binta reported that this often created friction between the midwives and the relatives. The midwives described this as a source of stress in their workplaces.

*Mostly the patient relatives are always aggressive and anxious. Immediately they bring in a woman in, they want you to stop everything you are doing and attend to them or else, they will become angry and aggressive (Binta, Hospital A)*

At times these situations were described as potentially frightening for the midwives as described by Hajara below.

*I saw patient relatives trying to beat a colleague of mine, so I had to come in, they won't listen to me, they were very aggressive, because she was trying to make them understand there is no bed space, and she was attending to a more serious patient. (Hajara, Hospital B )*

#### *Attending to a traumatic birth*

It was evident from the interviews that one of the most difficult times for the midwives was dealing with a traumatic birth, often involving the death of a mother and/or the baby. Many participants described how they felt affected by the traumatic births they witnessed because they were, 'feeling for the woman'. Midwives described dealing with many maternal deaths as a major source of stress, they struggled with their own emotions while at work and after work hours. Feelings of responsibility, guilt and a sense of failure were commonly shared by many of the participants as they recalled witnessing a traumatic birth.

Mariyah described how terrible she felt following a traumatic birth experience:

*The most awful one is when it is fresh stillbirth, it is painful. I remembered when I conducted of a childbirth and it was a fresh stillbirth, I went home I was so sad, feeling as if I was the cause of that (Mariyah, Hospital B).*

The above data extract emphasises how the participant felt responsible for women's experiences even if she was not directly responsible for the outcome. This feeling was typical among many of the participants. This has implications for the wellbeing of the midwife and contributes to the adversity experienced.

### **Perceived responses to the adversity experienced**

#### *Being abusive*

Participants described reacting inappropriately or even aggressively to mothers who were seen as 'not cooperative', they explained that their behaviour was protective to save the babies' lives. For example, participants explained that sometimes the women adopted a position not appropriate for the baby's birth, in which case they sometimes felt they had to scream at the women or communicate harshly so that the mothers understood that they needed to cooperate. Some of the midwives talked about 'slapping the women's laps' whilst they were in labour and explained that they did this to encourage their cooperation. Aisha reported some of her experiences as below:

*Because of the uncooperative attitude of some of them, you may see a woman is pushing, the baby is coming out, the patient is trying to close her legs, that baby might be affected, so you have to slap the laps so that the woman will open her legs, she may refuse to open the legs, you may have to pull it yourself (Aisha, Hospital B)*

According to Jummai, midwives sometimes communicate harshly with women because they fear the loss of the baby.

*So, to avoid the death of the baby, you really have to be very strict in second stage of labour, you tell her, 'if you don't push, if you don't do this, this is what you are going to receive', [loss of the baby] and most women*

*once you tell them like that then you see them they cooperate. (Jummai, Hospital A)*

This behaviour to the woman can appear abusive and disrespectful, and may be frightening for the women, as it may further influence their perception about the midwife and result in a negative childbirth experience.

One of the participants justified why aggression is an appropriate reaction to the women's behaviour. Binta reported that due to staff shortages, midwives feel pressured by a heavy workload. She pointed out that working alone without any assistance resulted in midwives reacting in a negative way to gain the women's cooperation.

*And being alone you don't have any assistant, you have to slap the lap so that the patient will open her legs to get the baby out, that is when I have to be aggressive, is for their own good .(Binta, Hospital B)*

#### *Delivering poor quality care*

One of the perceived effects of the workplace adversity described by the participants was the quality of care provided to the women. Most of the participants described how compromised quality of care presented a challenge to their beliefs, but they felt there was nothing they could do about it. It was observed from the interviews that the midwives felt torn between the ideal of good quality care and the care that they could provide. The participants described rushing care in order to deal with their heavy workload, staff shortages, high patient workload, pressured work environment, and lack of resources.

Maimuna reported that the impact of staff shortages on midwives resulted in tiredness due to a heavy workload and the inability to provide quality care to mothers.

*Because the midwives are short, the care we are supposed to give is not adequate, because of the workload, you will be tired, so you cannot give them what you are supposed to give them [quality care]. (Maimuna, Hospital A).*

## Discussion

This study explored midwives' experiences of workplace adversity in Nigerian hospitals and how they felt it impacted on their wellbeing. The challenges of staff shortages and excess workloads described in this study are not specific to Nigeria but have also been reported in midwifery and nursing professions in other LMICs such as Senegal and Malawi (Rouleau et al., 2012; Bradley et al., 2015). However, only a few studies conducted in other low and middle-income countries were midwifery specific. For instance, Adolphson et al. (2016) conducted a qualitative study in Mozambique aimed at exploring midwives' experiences of working conditions, perceptions and attitudes towards mothers. Findings from their study cited a shortage of human resources and a high workload as a source of stress and frustration for these midwives. Similarly, Bradley and colleagues (2016) used a qualitative design to explore perceptions of emergency obstetric care providers on the critical factors of staff shortages and workload in the health facilities in Malawi. The findings from their study showed that the participants were feeling stressed and frustrated by staff shortages and dealing with large numbers of patients that exceeded their capacity to cope. These stressors resulted in midwives leaving the profession (Bradley et al., 2016). Already burdened by a high maternal and infant mortality rate and heavy workloads, and inadequate resources necessary for the provision of high-quality care, among other challenges, the midwives in this study were left feeling frustrated and poorly motivated. Such feelings can result in midwives leaving the profession, as Bradley et al (2016) found.

The situation for the midwives in this study echoes findings from a global consultation (Filby et al., 2016) with 2,470 midwives in 93 LMICs, including Nigeria. The results of that study showed that midwives experienced difficult work situations due to shortage of staff, heavy workloads and high levels of maternal and new-born mortality. This made them feel frustrated, guilty, and inadequate. These difficulties can contribute to distress and burnout, which in turn prevents midwives from being

able to provide quality care and can eventually influence their decision to leave the profession (Filby et al., 2016).

In relation to the issue of resource shortages, findings from our study were consistent with the few studies conducted in Nigeria among nurses and other health care workers (Anyebe et al., 2014; Ladan et al., 2014; Kuforiji, 2017). These studies also identified poor quality equipment and inadequate supplies in government hospitals as a source of frustration and low morale amongst nurses. Similar findings were also reported in a qualitative study conducted in Mozambique where a lack of equipment was a source of stress and frustration for midwives (Aldolphos et al., 2016). Additionally, a recent study in the Democratic Republic of Congo (Bogren et al., 2020) aimed at exploring the challenges and factors that motivate midwives' retention in their workplace, found that a lack of resources and equipment including space, basic essential clinical equipment for labour and birth, shortage of electricity and birthing beds, all served as a source of constant frustration and a great challenge for the provision of care. Bradley and McAuliffe (2009) argued that in Malawi, health-related resource constraints worsen the issue of workload by causing "time-consuming struggles to improvise" which may negatively affect maternal outcomes. In their follow-up paper, Bradley et al. (2016) further identified poor work environments and lack of resources as part of the health system structural drivers resulting in disrespect and abuse of mothers. Lack of resources while providing care may lead to a poor quality of care, this in turn may result in maternal death and further increase the high maternal mortality in Nigeria (Olonade et al., 2019). Also, the poor work environment has been reported as among the push factors responsible for the skill migration of nurses and midwives in Nigeria (Okafor and Chimereze, 2020). This may further contribute to staff shortages. The availability of appropriate facilities and sufficient resources is regarded as necessary for staff motivation and performance (WHO, 2016).

The findings of our study offer insights into the relationship between workplace adversity and the mistreatment of women during childbirth or disrespectful midwifery care, as reported by many studies ( Bradley et al, 2016; Bohren et al., 2019; Dahab and Sakellariou, 2020). Relationships between women and midwives are of critical



importance, as an expectation of difficult relationships may influence women's choice of health care facility as well as the decision about whether to give birth at a facility or not. This has been found in Tanzania, Ethiopia ( Bradley et al., 2016) and even in Nigeria (Ogu et al., 2017). As births are rarely attended by a skilled birth attendant outside of a health facility (ten Hoop-Bender et al., 2014), this may increase the maternal and infant mortality rate of the country.

Similar to the midwives in our study who described a 'lack of cooperation' from some women during childbirth, this was also a source of stress for some midwives in Uganda and Malawi as they described struggling with uncooperative women during labour (Bakinbinga et al., 2012; Bradley et al., 2019). Bradley and colleagues (2019) systematic review on midwives' perspectives on the drivers of disrespectful intrapartum care in sub-Saharan Africa, found that controlling women's bodies, particularly during the second stage of labour, was seen as a core component of care. This included restrictions on what women were allowed to do while in labour, for example midwives dictating when the mothers should push. The midwives in our study described women as being challenging to care for in the second stage of labour and, as such, described their actions as being 'uncooperative'. The controlling nature of these midwives is tantamount to disrespectful care where women are made to appear as a bystander in their own birth experience (Bradley et al., 2019). Bradley and colleagues (2019) found that the trigger point was that the midwives needed to feel in control of the pushing stage. When women failed to respond to such midwifery control, they were referred to as being 'uncooperative'.

In order to understand (but not condone) this, it is necessary to appreciate that this is a crucial stage of labour when there could be damage to mother and/or baby, and midwives could be blamed. Midwives are relatively powerless in the hospital hierarchy and so feel they need to protect themselves and of course the women are even lower in this hierarchy (Filby, et al., 2016).

Our study demonstrated that midwives experience stress when dealing with maternal and neonatal related deaths despite their prevalence in the setting. Research suggests that caring roles are associated with 'secondary traumatic stress', post-

traumatic stress disorder and burnout. Leinweber and Rowe's (2010) study on the cost of being with the woman concluded that midwives' empathic relationships with women places them at risk of experiencing secondary traumatic stress. They suggest that this has harmful consequences for midwives' mental health and for their capacity to provide care for women. Dartey and colleagues (2017) also confirm that experiencing trauma at the workplace, such as the death of a woman, interferes with the general well-being and performance of midwives. Burton and WHO (2010) collaboration emphasised the importance of occupational wellness for all, to enhance mental health at the workplace. Stakeholders must understand that continued lack of psychological support for midwives may lead to midwives leaving the profession. This will add to the workforce shortages and may also compromise the quality of care provided to women and babies resulting in poor maternal and infant health outcomes.

### **Implications for midwifery education, policy and practice**

The findings of these study have implications for midwifery education, policy and practice. A shortage of maternity health workers, including midwives, may jeopardise the universal access to high-quality maternal care necessary for achieving the targets of Sustainable Development Goal 3 (Ogu, et al., 2017). Thus, attention must be paid to workload issues resulting from staff shortages in Nigeria, as midwives' retention in their workplaces is essential in order to tackle the high maternal mortality rate. The issue of staff shortage is also critical issue to policymakers in Nigeria; improving staff levels in the country would help promote the well-being of the midwives so they can, in turn, support the mothers for an optimum birth experience and sustained use of maternal health services. It is also necessary that at the macro level, stakeholders or the Federal Government of Nigeria should develop a policy to enhance sustainable human resource development that would promote the recruitment, distribution, and retention of midwives to deal with the poor maternal and new-born health outcomes in Nigeria. Also, there should be a thorough restructuring of services to improve the functioning of PHCs and general hospitals so as to reduce the burden on tertiary health institutions.

It is essential that the Nigerian government at all levels improve the availability of resources and functioning facilities to meet the supply of care services, to enable midwives to provide high-quality care. And so, to retain midwives in their workplaces and enable them to provide care of high quality, it is imperative to create supportive work environments by ensuring there are good working conditions. It is also important for midwives to take control to influence their situation by introducing political thinking into initial and continuing education (Filby et al., 2016). When midwives have been involved in designing their work environments, it has led to an improved quality of care for women and new-borns around the globe (WHO, 2016). This could be achieved by “investing in midwifery leadership and governance by creating senior midwifery positions” (UNFPA, ICM and WHO, 2021.p.vii) in various key areas so as to influence and change the midwives’ work situations. Although this action may need to happen at the managerial level, individual midwives need to be prepared to step up and take on these roles.

Additionally, hospital managers should be proactive in the provision and availability of resources including consumables needed to provide quality maternity services. This should then make these primary and secondary facilities more attractive to both women and midwives, and hence reduce the workload on tertiary health facilities.

Finally, any planned training on the delivery of respectful maternity care in LMICs would also need to address structural issues around provider workload and resources if it is to have any impact. It is crucial that attention and intervention should be directed at modifying the behaviour of the midwives and dealing with some of the problems they experience in their workplace. If some of the problematic situations in their working environment are addressed, the midwives may feel supported and validated and may not need to resort to abusive behaviour to feel in control.

## **Strengths and limitations**

One of the strengths of this study is the use of grounded theory as a methodology. The relatively limited literature regarding the experience of workplace adversity and

resilience among midwives has been noted earlier and using the constructivist grounded theory in this study has provided deeper insights about the midwives' experiences while supporting women during childbirth. One of the limitations of this research was the relatively small number of participants, and the study was conducted in only two tertiary hospitals within one geographical location and as such the experiences of midwives in settings like the primary and secondary care were not included. As a result, these findings may need to be interpreted with caution, as transferability may be limited.

## **Conclusion**

Participants in this study experienced workplace adversity fuelled by high caseloads, workforce shortages, lack of basic equipment /consumables, an unsupportive working atmosphere, difficult relationships with women and attending to traumatic births. More investment in Nigerian maternity services is needed to improve quality of care provision and reduce adversity within the midwifery workforce and so enhance staff retention.

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## **Author's contributions**

HMA, BH, LW and DS conceived and designed the study including the interview guide. Data collection and analysis was led by HMA. The manuscript was written with support from BH, LW and DS. All authors read and approved the final manuscript.

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