

**EXPLORING MIDWIVES' EXPERIENCES OF WORKPLACE
ADVERSITY AND RESILIENCE IN NORTHERN NIGERIA: A
CONSTRUCTIVIST GROUNDED THEORY**

Thesis submitted for the degree of Doctor of Philosophy

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Dedication

This thesis is dedicated to my late brother Aliyu Musa and my niece Jamila Salifu who both died after a major illness during my PhD journey. My brother was a huge pillar of support throughout my entire midwifery career, my chauffeur during my data collection and was a father figure to my kids while I was away. May God place them among the dwellers of the highest place in paradise!

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Summary

Background

This thesis reports on a study that explored midwives' experiences of workplace adversity and resilience in tertiary hospitals in Northern Nigeria. Previous research exploring midwifery resilience had been limited to high-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. Understanding more about why and how some midwives are able to withstand workplace adversity and remain positive and motivated could benefit the midwifery profession in Nigeria by enhancing staff retention. The study aimed to generate a theory of midwives' workplace adversity and resilience.

Methodology and Methods

This research used a constructivist grounded theory approach. Interviews were conducted in two phases with practising midwives working in maternity units of two tertiary health institutions. Purposive sampling, followed by theoretical sampling, was used to select participants. Semi-structured face to face interviews were conducted over a nine-month period with concurrent data analysis. Flexible guides were developed for the interview and the research questions. A total of 34 interviews were conducted with twenty participants. Field diaries and notes were utilised for additional data. Categorising of interview transcripts was supported by NVivo 12.

Results

The key findings were that significant adversity was caused by: severe lack of human and material resources, attending to traumatic births and relational challenges. The major resilient strategies included: using improvisations, drawing on spirituality, having a sense of purpose linked to calling and vocation, and building interpersonal relationships. From these insights, the theory of midwives' workplace adversity and resilience was developed.

Conclusion

Urgent attention needs to be paid to all the significant sources of adversity identified, as the retention of midwives within their workplaces is essential in order for Nigeria to improve its high maternal and infant mortality rates. Improved ways of supporting staff should be identified and education about building resilience and respectful maternity care should be introduced.

List of abbreviations

AHWO	Africa Health Workforce Observatory
ASSIA	Applied Social Science Index and Abstracts
CHEW	Community health extension worker
CHO	Community health officer
CINAHL	Cumulative Index of Nursing and Allied Health Literature CIPD: Chartered Institute of Personnel and Development.
CNO	Chief Nursing Officer
DFID	Department for International Development
FMoH	Federal Ministry of Health
GDP	Gross Domestic Product
HIC	High income countries
ICM	International Confederation of Midwives
LMICs	Low- and Middle-income countries
MBI	Maslach Burnout Inventory
MDG	Millennium Development Goals
MMR	Maternal mortality rate
NANNM	National Association of Nigerian Nurses and Midwives
NDHS	Nigeria Demographic and Health Survey
NGO	Non-governmental Organisation
NHS	National Health Service
NMC	Nursing and Midwifery Council
OHSF	Office of the Head of Service of the Federation
PHC	Primary Health Centres
RCM	Royal College of Midwives
RCN	Royal College of Nursing
SDG	Sustainable Development Goals
SoWMy	State of the World's Midwifery

UNDP	United Nations Development Programme
UNFPA	United Nations Populations Fund
UNICEF	United Nations Children's Emergency Fund
WHO	World Health Organisation

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CHAPTER ONE - Background to the study

1.1. Introduction

There is a growing interest in the concept of resilience within the healthcare workforce because nurses and midwives' workplaces have become more demanding, irrespective of the country (Glass, 2007). Early researchers like Wagnild and Young (1993) define resilience as adjusting well to significant stress and adversity. Hunter and Warren (2014, p.7) also describe resilience as an individual's ability to respond, 'positively and consistently to adversity using an effective coping mechanism'. Additionally, resilient individuals have been said to have the capacity to respond to adversity by either maintaining normal performance and an abiding sense of well-being or by an eventual return to favourable outcomes through activating their resilient responses (Ablett and Jones, 2006; Tugade and Fredrikson, 2007). The common theme in the varied definitions is that individuals cope better in adversity by becoming resilient.

Recent evidence also suggests that depression, burnout, and stress are prevalent amongst nurses and midwives (Thorsen et al., 2011; Khamisa et al., 2013; Creedy et al., 2017) and account for one-quarter of all cases of sickness absenteeism (NHS, 2014). Poor staff health can result in an upsurge in medical errors (Harrison et al., 2014), infection rates (Boorman, 2010), and mortality rates (Keogh, 2017), thus affecting patient safety (Pezaro, 2016b). Midwives are exposed to higher stress levels than general health care workers (Kirkham, 2007; Leinweber and Rowe, 2010). This may be connected to the nature of their work which requires dealing with women's emotions, suffering and sometimes maternal and neonatal death (Hunter, 2001; Hunter, 2003; Hunter and Deery, 2009; Leinweber and Rowe, 2010). As a result, midwives may experience higher rates of burnout symptoms, depression, secondary trauma, Post-Traumatic Stress Disorder (PTSD) and compassion fatigue than other health care professions (Sabo, 2006, Leinweber and Rowe, 2010). Given these reasons, it becomes pertinent to explore adversity and resilience amongst midwives.

Within the past decade, research interest on the construct of resilience has increased across various disciplines, including nursing science. These studies explore the association between the levels of resilience and outcomes, such as reported levels of stress and burnout, compassion, fatigue, and general indicators of well-being (Garcia-Dia et al., 2013). One of the first studies focusing specifically on midwives' resilience was conducted in the United Kingdom in 2013 (Hunter and Warren, 2014). The study noted that the emotion work that midwifery entails remains mostly unrecognised and poorly

valued by employers (Hunter and Warren, 2014). Given this reason, there may be a need for midwives to develop resiliency so as to provide effective and efficient care to women. These issues are not just of concern in high-income countries but are even more prevalent in low-income countries with associated factors. These factors will be explored in the next section.

1.2. Shortage of midwifery workforce

A shortage of experienced nurses and midwives is one of the challenges currently being faced by health care provision globally (Ten Hoop-Bender et al., 2014). Thorsen and colleagues (2011) assert that sub-Saharan Africa has been faced with challenging health systems and a limited-service delivery quality caused by limited human resources. As a result, the existing health care workforce often carries an overwhelming workload (Thorsen et al., 2011). Health worker shortage in sub-Saharan Africa is associated with many causes, these include past investment shortfalls in pre-service training, migration of healthcare professionals to other countries, and career changes amongst health workers (Martines et al., 2005; Zurn et al., 2005). For example, South Africa is faced with an estimated shortage of 32,000 nurses/midwives (Oulton, 2006) with a total of 47,390,800 patients served by 101,295 professional nurses in 2006, a ratio of 468 patients to 1 nurse (Wildschut and Mgqolozana, 2008). This has resulted in stress amongst its workforce as nurses and midwives reported feeling emotionally overloaded, helpless, and frustrated (Koen et al., 2011). Many of these health workers experienced job dissatisfaction, moral distress and lack of personal accomplishment and for these reasons often left the profession (Koen et al., 2011).

Nigeria is ranked 7th out of 57 countries in the WHO regions (African, American, South East Asian, European, Eastern Mediterranean and Western Pacific regions) with a gross shortage of human resources for health (Speybroeck et al., 2006; Ebuehi et al., 2011). In 2017, the Nigerian Health Minister stated that Nigeria had a shortage of 144,000 health workers and ranked second in Africa behind Ethiopia with a 152,000 shortage of health workforce. He further noted that the country currently had 240,000 midwives and nurses, and that by 2030, it was projected to require approximately 471,353 nurses and midwives in order to provide care for its growing population. However, it is estimated that only 333,494 midwives and nurses will be available by 2030. This means there will be a shortage of 137,859 midwives and nurses to provide quality care to patients (Ikumola, 2017). Eriki and colleagues provided the following as the reasons for health worker shortage in Nigeria:

(a) 'insufficiently resourced and neglected health systems; (b) poor human resources planning and management practices and structures; (c) unsatisfactory working conditions characterised by heavy workloads, lack of professional autonomy, poor supervision and support, long working hours, unsafe workplaces, inadequate career structures, poor remuneration, poor access to needed supplies, tools and information, limited or no access to professional development opportunities; and (d) internal and international migration' (Eriki et al. 2015, p.3)'.

These challenges may result in serious workplace adversity. Strategies are required to support staff working in such situations.

When looking specifically at the midwifery workforce, Nigeria is ranked as one of the 73 countries in Africa, Asia, and Latin America represented in the State of the World's Midwifery Report 2014 with a grossly inadequate number of midwives (Ten Hoop-Bender et al., 2014). These shortages were also reported by 194 countries, including Nigeria, in the recently released State of the World's Midwifery as experiencing a shortage of midwifery workforce (UNFPA, ICM and WHO, 2021).

Approximately 78% of the country's health facilities are facing a shortage of midwifery workforce to provide appropriate care to women which could result in avoidable maternal and infant mortality (Ten Hoop-Bender et al., 2014). This is reflected in the World Health Organisation's estimates of maternal mortality (WHO, 2015), with Nigeria contributing 58,000 (19%) maternal deaths to the global estimate of maternal deaths. Nigeria has one of the highest maternal mortality rates in the world, with 814 deaths out of 100,000 live births (UN Interagency Group for Child Mortality Estimation 2013; WHO, 2015) and an infant mortality ratio of about 69 per 1,000 live births. In 2017, an estimated 295,000 maternal deaths occurred globally due to pregnancy and childbirth complications, out of which sub-Saharan Africa and Southern Asia accounted for approximately 86% (254,000) of the estimated global maternal deaths (WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division, 2019)

However, Nigeria is not alone amongst Sub-Saharan African countries in experiencing these high mortality rates. Global maternal deaths are highest among many sub-Saharan African countries. Maternal death estimates in most of the highest mortality countries are above 500 maternal deaths per 100,000 births, with peaks reaching above 900 in Chad and Sierra Leone (Chamie, 2016). These statistics are in stark contrast with those from other countries. For example, the United Kingdom has a maternal mortality ratio of 9.02 per 100,000 live births and an infant mortality ratio of 3.8 deaths per 1,000 births. For these reasons, all midwives in Nigeria are challenged to reduce this figure by providing a high quality of care. These challenges may increase pressure on the midwife and may

further contribute to workplace adversity. Therefore, becoming resilient may be one of the strategies needed by the midwife to enable them to provide quality midwifery care and to achieving the United Nations Sustainable Development Goal 3 health for all. The target for this goal is a reduction in maternal deaths to 70 per 100 000 live births in 2030 (WHO, 2015; UN, 2015). Finally, related to this study is the Goal 3 C, which focuses on "... the recruitment, development, training and retention of the health workforce in developing countries" (UN 2015, p17). Thus, this study's findings and recommendations may contribute to achieving SDG 3.1,3.2, and 3c in the Nigerian context and other LMICs.

1.3. Workplace adversity

Although published research relating to resilience in Nigeria is lacking, two studies have explored stress among health workers including doctors, nurses and midwives in the area. They provide an insight into the levels of adversity experienced by health workers (Anyebe et al., 2014; Ladan et al., 2014). Both studies recommended that clinicians' need to ensure their workload is in line with their capabilities and suggest various stress management techniques. Neither of these studies mentioned the concept of resilience. Also, there is a lack of qualitative studies in this area to enhance the understanding of the findings. Thus, this current study would build on the findings of these previous studies.

Midwives are responsible for two lives, that of the mother and her offspring. However, this responsibility becomes more challenging in the Nigerian context where direct obstetric causes of maternal death such as hypertensive disorders and postpartum haemorrhage, coupled with delay in seeking medical help due to poverty and ignorance are prevalent (Guerrier et al., 2013). Often, the delay in seeking medical help results in admission to medical facilities of mothers in severe states of ill health and midwives being tasked with providing emergency care to save these mothers and their babies' lives. 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 ill-health and result in staff shortage which may further exacerbate pressure on the remaining midwives. From my professional experience, these midwives' shortages with harsh work environments, 'characterised by inconsistent supplies of basic commodities and supplies' appear to make it difficult for midwives to provide quality care to their client (Bradley et al., 2019, p.3). These health institutions' challenges, with the increasing numbers of facility-based births notable in tertiary hospitals, poverty on the part of the women and inadequate resources result in a 'perfect storm' (Bradley et al., 2019, p.3) creating a sense of adversity for these midwives. However, Hunter and Warren (2014)

further pointed out that despite the adversity experienced, some midwives can adjust and cope with stress. Kirkham et al., (2006) highlighted those midwives are able to move on not because of the financial aspect of the job but because they want to keep caring for these women. Understanding how some midwives can withstand workplace adversity and remain positive and motivated could benefit Nigeria's midwifery profession. Studies of workers' wellbeing conducted in other countries have indicated that resilience is an important factor (Jackson et al., 2007). Thus, the need for this current study.

Pincombe and colleagues noted that midwives dealt with 'life in the raw'; life as it is lived by women who rely on them for information, support, and guidance (Pincombe et al., 2015, p. 365). They further noted that each midwife had to develop the ability to deal with what is happening in the 'here and now' and to continue to work with each woman and her family to support them through their overall experiences (Pincombe et al., 2015, p. 365). This required emotional strength as well as the ability to keep thinking, assessing and planning whatever the circumstances (Pincombe et al., 2015). This then can be seen as resilience: the capacity to bounce back in adversity, 'pick yourself up after being knocked over and move on' (Pincombe et al., 2015, p.365). Midwives who are stressed are less likely to give good quality safe care to mothers and their babies (Ten Hoop-Bender et al., 2014) thus it is pertinent to find out how best to support the midwives so they, in turn, can better support and care for mothers. Current evidence from the UK suggests that this could be achieved by adopting resilient strategies, these include recognising triggers or warning signs of stress, avoiding hindering relationships and addressing problems as they arise (Hunter and Warren, 2014). The lack of literature on the understanding and the experience of resilience among midwives in Nigeria also necessitated the conduct of this study.

1.4. Statement of problem

Several authors have recognised midwifery as an emotionally demanding job and even more demanding in the face of the shortage of midwifery workforce globally (Hunter 2001, Hunter 2003, Hunter and Deery 2009, Hunter and Warren 2014; Ten Hoop-Bender et al, 2014). From my knowledge and professional experience, the tertiary delivery suite in Nigeria is an unpredictable environment where midwives are team members working closely with other health care professionals. It is also a centre of learning where the medical, midwifery, pharmacist, medical laboratory and basic nursing students are posted to acquire their clinical experience. In addition to this, resident doctors are usually on clinical obstetrics and gynaecology training programmes and there are also medical house

officers on three-month rotational experience. This results in frequent staff changes and makes the unit a bustling and stressful place to work.

Additionally, tertiary hospitals are referral centres in the country, created to receive complicated cases referred from primary and secondary health facilities and private hospitals (Ogu et al., 2017). On the other hand, the Primary Health Care (PHC) is designed to be the community first point of contact into the formal healthcare system (Abdullraheem, Oladipipo and Amodu 2012) from where pregnant women with complications are referred to either secondary or tertiary health centres for further management (Ogu et al., 2017). However, due to the inadequate functionality of primary health centres throughout Nigeria, the majority of patients reportedly avoided the PHC facilities to self-refer to the tertiary care centre in Nigeria (Ogu et al., 2017; Koce et al., 2019). Women prefer to utilise secondary and tertiary health facilities directly rather than go through primary health centres (Katung, 2001; Ehiri et al., 2005). The private health facilities also flourish in many parts of the country; however, the high cost of services prevents women accessing private maternity services (Ogunbekun et al., 1999). This may be responsible for the increasing number of women utilising the few existing public secondary and tertiary health facilities for maternal health care services. This results in a growing number of patients being catered for in the tertiary hospitals, thus increasing the pressure on midwives and contributing to workplace adversity.

Furthermore, hospitals in Nigeria are faced with increasing commercialisation due to out-of-pocket payments for clients' health services. Out of pocket payments refers to payments made at the point of service either fully or subsidised. Out-of-pocket expenditures constitute nearly 60% of the total private health spending, placing a significant burden on households (Olakunde, 2012; Uzochukwu et al., 2015; Michael, et al., 2019). Increasing out-of-pocket expenditure has affected the relationship between the service users' and the healthcare workers (Aytec et al., 2009). As a result, various types of violence, including physical and verbal, within the hospitals has been recognised as an issue for health service providers in LMICs where the individuals pay for expensive health charges. Patients are usually under stress and in pain and with the effect of catastrophic health expenditure incurred may resort to aggression at the slightest provocation. This may result in a shift of aggression towards health workers (Aytaç et al., 2009). This could further contribute to the workplace adversity experienced. Current evidence from studies in this setting has shown that the midwives felt under siege in their workplace (Anyebe et al., 2014). Thus, it is important to find out how best to support these midwives by exploring the ways in which some midwives cope in the face of adversity.

Filby et al. (2016) utilised a systematic review to identify barriers to the provision of quality midwifery care in low and middle-income countries from the provider's perspective. The items generated from the search were screened against inclusion and exclusion criteria yielding 82 articles from 34 countries. About 44% of the articles discussed countries or regions in Africa, 38% in Asia, and 5% in America. The items generated were further organised into three categories namely social, economic, and professional barriers to the provision of quality midwifery care. The professional barriers identified were inadequate staffing levels and an increased workload across urban and rural settings. This was further supported by a report concerning African countries, which stated that inadequate staffing and working overtime compromised safety for women and their midwives (Filby et al., 2016). The authors suggested that moral distress and burnout resulted in the inability of midwives to provide quality care. They also indicated that there might be a link between burnout and the mistreatment of women during childbirth or disrespectful midwifery care, as reported by many studies (Chen et al., 2004; Filby et al., 2016; Bradley, 2016; Bohren et al., 2017; Danab and Sakellariou, 2020). Filby et al., (2016) concluded that long term effects of burnout and moral distress could result in poor retention of maternity staff. Poor retention can worsen the problems facing midwifery workforce and increases pressure on those that remain (Hunter and Warren, 2014; Filby et al., 2016). These findings confirm the prevalence of stress and burnout among the midwifery workforce across the globe as a result of workplace adversity.

Workplace adversity is thought to be one of the primary reasons that nurses and midwives fail to thrive in their workplace and hence leave the profession (McDonald, 2010). A qualitative study conducted by McDonald (2010) in Australia revealed that workplace adversity caused distressing personal and professional burdens to the participants, including loss of self-esteem, self-confidence, critical thinking, and professional decision-making capacities. Participants further stated that they experienced a range of negative health and wellbeing effects from their workplace such as constant fatigue, sleeplessness, chronic pain, stress, and anxiety (MacDonald, 2010). However, despite the workplace adversity, some participants coped well and attributed their survival and ability to thrive to a variety of factors such as established careers, support networks and familiarity with organisational policies and processes within the selected hospital. They reported that their years of experience had taught them many ways to stay healthy enough to survive and withstand, even thrive, amidst workplace adversity (MacDonald, 2010). This indicates that resilience may have developed throughout their career.

1.4.1 Personal reflections and justification for the study

In the earlier part of my career as a student midwife, I observed that the midwives in the delivery suite sometimes exhibited unprofessional behaviours to both junior midwives and patients in labour. This may have been as a result of pressure that places demand on their emotional, psychological and physical reserves (Crowther et al., 2016). Filby et al., (2016) confirmed that moral distress and burnout among midwifery personnel affected the quality of services and patient outcomes through the adoption of negative and unprofessional behaviours. Also as a woman in labour myself, I observed unfriendliness among some of the midwives in the delivery room which was later discussed with the other women in the lying in ward after birth. This anecdotal evidence as both a midwife and a mother has led me to propose this research study. My experiences and observations and the literature gap regarding the experience of workplace adversity and resilience amongst midwives in Nigeria indicates a great need for more studies to be conducted. 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 United Nation's Sustainable Development Goal 3- reduction of maternal and infant deaths. This current study will explore midwives' experience of workplace adversity and resilience in Northern Nigeria.

1.5. Aim of the Study.

The study aims to explore the phenomenon of workplace adversity and the experience of resilience among midwives, and to develop a middle range theory on workplace adversity and resilience grounded in empirical data.

1.6. Specific Objectives

1. To explore the characteristics and experiences of workplace adversity among midwives working in tertiary level hospitals in Northern Nigeria.
2. To explore these midwives' understanding of the construct of resilience and resilient strategies.
3. To explore these midwives' views about various resilient strategies they use for dealing with workplace stressors.
4. To develop a middle-range theory of midwives' workplace adversity and resilience.

1.7. Significance of Study

An initial review of the literature found no evidence of studies exploring professional resilience amongst midwives practising in Sub-Saharan Africa in the context of high maternal and infant mortality. Nigeria needs to ensure that the midwives are thriving in their work and able to give safe, high quality and compassionate care, so that women want to use the services. Therefore, the outcome of the study has the potential to:

1. Describe how the phenomenon of workplace adversity is experienced by midwives and provide recommendations for relevant improvement that may enable the midwives to thrive better in their workplace and be more able to give safe compassionate care to mothers.
2. Inform policy and practice with regard to the concept of professional resilience from the resilient strategies adopted by the participants.
3. Provide a theory for building professional resilience that may help address the shortage of midwifery workforce in Nigeria and beyond.

1.8. Operational definition of terms

1. Workplace adversity: This refers to a range of stressful, negative, and difficult situations generated from the work environment.
2. Resilience: This refers to the ability to bounce back and move on in the context of a stressful environment or coping in the face of adversity.
3. Midwives: This refers to registered nurse-midwives currently working in the obstetrics and gynaecology unit. In the Nigerian context, all midwives working in the tertiary and secondary care facilities are double qualified.
4. Middle range theory: This refers to theory developed inductively and grounded in the empirical data. This is described in depth in Chapter 10.

1.9. Organisation of the Thesis

Chapter One introduced the study with the aim and research questions along with my own personal reflections on the research problem. A brief introduction to workplace adversity and the causes including shortage of workforce and the need for resilience were briefly explained. The significance of the study, operational definition of terms and the thesis structure was also detailed.

Chapter Two provides a contextual description of Nigeria where the study was conducted and an overview of the Nigerian Healthcare system and the methods of financing health care in Nigeria. It also describes the cadre of staff providing care at the different levels of the healthcare system. The current status of maternity care services is discussed, including maternal mortality rates and an overview of midwifery training in Nigeria. In addition, an outline of the United Nation's 2030 Sustainable Development Goals (SDGs) especially SDG3C and its relevance to this study is discussed.

Chapter Three reviews the research evidence relating to workplace adversity and resilience in midwifery and nursing. It also provides a general overview of the concept of workplace adversity and resilience and more specifically the implications for the midwives within a Nigerian setting. The literature review identifies a gap in the existing knowledge of midwives' experiences of workplace adversity and resilience and the research focus is therefore developed.

Chapter Four describes the methodology, its philosophical underpinning, and the research design for this study. It also presents the differences among the various grounded theory studies. It discusses the rationale for choosing constructivist grounded theory.

Chapter Five presents the methods; the way in which constructivist grounded theory was used in the study. It also provides a detailed description of the data collection methods and data analysis; this includes a description of how the coding paradigm was used to link the categories. Ethical considerations, the quality and limitations of the study are also considered.

Chapter Six presents the demographic characteristics of the respondents and explains the criteria for selecting the theoretical samples.

Chapters Seven to Nine present the findings and analytic discussions of the data using the Charmaz and a 'Coding paradigm framework (Strauss and Corbin, 1998, p.123) to develop an understanding of how midwives develop resilience in the face of workplace adversity in maternity wards in Nigeria. Chapter Seven examines the category 'Experiencing workplace adversity' under two subcategories. Chapter Eight presents the meaning of resilience and the 'Managing and Thriving' category. Chapter Nine provides the Impact of institution environment on resilience, which was the institutional base strategy for resilience. As a consequence of the different strategies, a 'Resilient midwife' was developed.

Chapter Ten integrates the categories developed from the three findings chapters to present the theoretical model 'Finding Perspective', this explains how the midwives use some of the key resilient strategies for finding perspective. The theory is discussed with

reference to relevant literature. These strategies were chosen by the resilient midwives as the key strategies for gaining perspective.

Chapter Eleven presents a discussion of the findings and what the findings mean in the context of LMICs and the retention of staff and reduction of maternal mortality necessary for achieving the sustainable development goals. It also discusses the theory of Lipsky, (1980) and its importance for the justification of some of the resilient strategies used by the midwives.

Finally, Chapter Twelve concludes the thesis by providing a summary of the thesis and its contribution to existing knowledge. Implications of the research findings for midwifery practice, education and policy are considered. The recommendations for future research are provided at the end. The study's strengths and limitations and the researcher's reflections are also described within this chapter.

CHAPTER TWO - Contextual Description of Nigeria

2.1. Introduction

This chapter provides an overview of the country of study, Nigeria. This includes the demography of Nigeria, the structure and characteristics of the healthcare system, financing healthcare in Nigeria, the healthcare workforce, and the features of the Nigeria midwifery workforce. The nursing and midwifery educational system will be described briefly and also Nigeria's maternal and infant mortality rates. The United Nations 2030 SDGs and their relevance to this study is also presented.

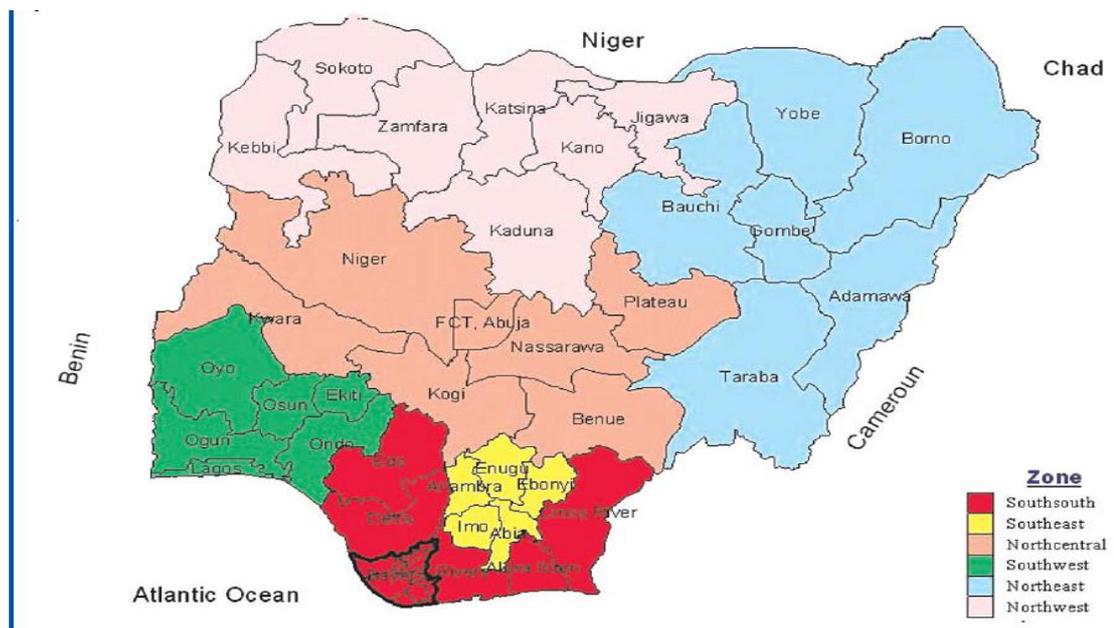
2.2. An overview of Nigeria's demography

Nigeria is situated in West Africa and is the most populous country in Africa (World Bank 2019a). It has 36 states divided into six geo-political zones, namely North-West (Jigawa, Kaduna, Kano, Katsina, Kebbi, Sokoto and Zamfara States), North-East, (Adamawa, Bauchi, Bornu, Gombe, Taraba, and Yobe States), North-Central, (Benue, Kogi, Kwara, Nasarawa, Niger and Plateau States and Federal Capital Territory), South-East, (Abia, Anambra, Ebonyi, Enugu and Imo States), South-West (Ekiti, Lagos, Ogun, Ondo, Osun and Oyo States) and South-South, (Akwa Ibom, Bayelsa, Cross River, Delta, Edo and Rivers States) [National Population Commission (NPC) 2014]. Nigeria covers 356,667 square miles of land, from the Gulf of Guinea on the Atlantic coast in the South to the borders of the Sahara Desert in the North (World Bank 2014a). The country has over 250 ethnic groups, including Hausa, Igbo and Yoruba, the major groups (NPC 2014). In terms of religious practices, Christianity and Islam are the two major religions in the country. It also has the largest economy in Africa with a Gross Domestic Product (GDP) of \$410 billion, a GDP growth of 2.2%, and 11.4% inflation in 2019 (World Bank 2019). In 2006, the last census conducted in Nigeria showed its population as 140,431,790 people with 71,345,488 men, 69,086,302 women and an under-five population of 29,697,225 (NPC 2014). However, the recent statistics revealed an increase in this figure to a total population of over 200 million in 2019 (World Bank 2019b). According to the United Nations world population prospects (2019), Nigeria's birth rate is 36.9/1000 compared to, for example, 12.3 in the United Kingdom (UK). The Nigeria Demographic and Health Survey (NDHS, 2018) reported that the total fertility rate (TFR) was 5.3 births per woman.

Furthermore, Nigerian women in rural areas have 5.9 children, compared to 4.5 children among urban women (NDHS, 2018).

The life expectancy at birth in Nigeria is 53 years for men and 55 years for women (World Bank, 2019). This is lower than high income countries (HIC) like the UK, where life expectancy in England and Wales is 79.3 years for men and 83.0 years for women (Office for National Statistics (ONS) 2019). Below is the Nigeria map showing the six geographical regions and Kaduna state where the study was conducted.

Figure 2. 1: A map of Nigeria showing the six geo-political zones and Kaduna state



Source: WHO (2007)

2.3. The Nigerian Health Care System

Asuzu (2002) defines a health care system as an organisational structure developed to meet a given community's health care needs. Nigerian healthcare services are provided across three levels of the health care system. These include the primary, secondary, and tertiary healthcare systems (Asuzu, 2002; Koce et al., 2019). Furthermore, Nigeria operates under three government tiers: Federal, State and local, these are all responsible for providing health services and programmes to the general populace (WHO 2002). Through the Federal Ministry of Health, the Federal Government is responsible for providing guidance, planning, technical assistance, and for coordinating the state-level implementation of the National Health Policy [Federal Ministry of Health (FMoH) 2009]. The Department of Hospital Services within the Federal Ministry of Health monitors and evaluates over 53 federal tertiary hospitals, including teaching hospitals, federal medical

centres and national eye and ear centres. While the State Ministries of Health are responsible for secondary care facilities, also known as the general hospitals. They are also responsible for regulating and providing technical support for the primary healthcare services at the local levels (FMOH, 2009).

The Nigeria healthcare system has been ranked at 187th among 190 United Nations member states in 2018 (WHO, 2018). The health care system has been reported as having a multitude of challenges. These include a general lack of basic infrastructure such as inadequate water supply, erratic power supply, lack of essential medicines and equipment, shortage of experienced health staff, lack of health care financing, poor remuneration and inadequately equipped laboratories, amongst others (Koce et al., 2019; Olanade et al., 2019). The flawed Nigerian health care system may be linked to inadequate leadership and poor governance, a weak political system marked with corruption with a high level of impunity, thereby hindering the provision of quality services and affordable health for the Nigerian citizens (Olanade et al., 2019).

Nigeria's health care delivery system is organised into three levels of care - primary, secondary and tertiary (Koce et al., 2019). The system operates concurrently such that all three levels of government are responsible for only one level each. However, the federal can extend its services to any of the other two lower levels of care (Asuzu, 2002). The three levels of care are described in the following paragraphs:

2.3.1. Primary Healthcare Centres

The primary healthcare centres are established in all the 774 local government areas of Nigeria (Olanade et al., 2019). It is the first point of contact with the health care system for most Nigerians. Pregnant women are expected to receive antenatal, intrapartum and postnatal care in the health care centres closest to their place of residence (Olanade et al., 2019). The primary health care centres are responsible for diagnosing and treating common ailments using appropriate technology, infrastructure, and essential medications (Badru, 2002). It is also the level at which health promotion and education efforts are undertaken and where patients in need of more specialised services are linked with secondary care (FMOH, 2004). The primary health care centres are within the scope of local government by the policy. According to the World Health Organization recommendations, the primary health care centres are expected to provide Basic Emergency Obstetric Care (BEmOC). They are also required to treat simple obstetric complications that do not require any surgical operations (Okonofua et al., 2018).

Primary health structures also provide maternal and child health care services, family planning, and immunisation (Badru, 2003). Finally, the primary health care centres are involved in record-keeping, case reporting, and patient referrals to higher tiers. The primary health care centres have community health officers, community health extension workers, nurses, midwives and very few doctors as healthcare workforce members (FMOH, 2004).

2.3.2. Secondary Care Facilities

This is the second level of care after primary health care. Secondary care facilities include hospitals usually located in big cities or in urban centres. They are managed and run by the state governments and are sometimes referred to as general hospitals. They can also be managed by a private individual or a group of people (FMOH, 2004). The secondary health centres are required to provide the prevention, treatments and management of minor complex cases (FGON, 2018). However, the more complicated cases are referred to the tertiary or specialist hospitals where there are many specialists and consultants in various fields of medicine and nursing. Examples of secondary care facilities are comprehensive health centres and general hospitals. The comprehensive health centres are often privately owned, while the government mainly owns general hospitals. The general hospitals have provision for accident and emergency and diagnostics, including X-ray, scan machines and other pathology services (Badru, 2003). There are some acceptable standards and infrastructure levels required in secondary care facilities (FGON, 2018). According to the Medical and Dental Council of Nigeria, there should be a minimum of three doctors who provide medical, surgical, paediatric and obstetric care in any general hospital (Badru, 2003). The secondary care facility provides simple surgical services, supported by beds and bedding for a minimum of 30 patients (FGON, 2018). There should also be ancillary facilities for proper diagnosis and treatment of common ailments. They have medical officers, nurses, midwives, laboratory and pharmacists, and community health officers as healthcare workforce members (FMOH,2004).

2.3.3. Tertiary Care Institutions.

A tertiary care institution, also called a specialist or teaching hospital, deals with complex health problems such as referrals from general hospitals or direct admission (FMOH, 2004). Similar to the general hospitals, they have units such as the accident and emergency unit, diagnostic unit, wards and outpatient consultation unit. All these units are equipped with the necessary facilities and staffed by skilled personnel (Badru, 2003).

Teaching hospitals also conduct research and provide outcomes for the government to influence health policies (FMOH, 2004). This explains why it is often university and urban-based.

Furthermore, teaching hospitals are supposed to be fully developed and accredited to teach various medical, nursing, midwifery and other allied health disciplines (FMOH, 2004). They are also required to conform with international and national acceptable standards. The tertiary institution is responsible for providing specialist care (Badru, 2003; Erinosh, 2005). As a result, each department is expected to have a certain number of medical consultants with its outpatients, consultation sessions, ward units, surgical sessions and skilled personnel to manage these units (FMOH, 2004). Tertiary health institutions are controlled and funded by the Federal Government and some states which have and run state universities (FMOH, 2004).

One of the problems with secondary and tertiary institutions is the increased women to health provider ratio. The secondary and tertiary care centres were established to provide comprehensive emergency obstetric care including blood transfusions and surgical operations (Ogu et al., 2017). With proper functioning of primary health care centres, approximately 70% of emergency complications would be handled at the level of basic emergency obstetric care, i.e., at the level of primary health care. Simultaneously, only a small fraction would require comprehensive emergency obstetrics care at the secondary and tertiary centres (Ogu et al., 2017). However, due to the inadequate functioning of the primary healthcare system, most emergencies are often referred, thereby increasing the workload and reducing the quality of care provided in secondary and tertiary hospitals (Ogu et al., 2017). Also, the women's perception of the inadequate functioning of the primary health care centres results in them seeking maternity services directly at tertiary health care, therefore increasing the workforce's workload in this tier of care (Ogu et al., 2017).

2.4. Health Care Financing in Nigeria

Health care financing involves the generation, allocation, and utilisation of funds for health care delivery. It is one of the essential building blocks of the health system. The method of health care financing of a country is a crucial determinant of the country's health status (Carrin et al., 2007). Health care in Nigeria is funded through taxes, health insurance, out of pocket payments and donor funding. It is important to note that health care financing methods are not mutually exclusive (Olakunde, 2012).

2.4.1. Taxed based/revenue

This is derived principally from the budgetary allocation to the health sector from the government's consolidated revenue at national, state and local government levels. This source of funding is dynamic, it depends on the amount of revenue accrued and the level of commitment of the ruling government on health. Nigeria is largely a mono-economy that derives over 90% of its revenue from the pursuits of oil resources; hence, the international market's fluctuating oil prices may affect the budgetary allocation to health (Uzochukwu et al., 2015).

2.4.2. Out of Pocket Payments

This comprises payments made at the point of service either entirely or subsidised. This may cover part or whole of the cost of services rendered, including consultations, diagnostic investigations, surgical or pharmaceutical services. Out of pocket payment is regarded as a regressive methodology of health care financing as it offers no protection from the risk of ill health to the consumer, especially the vulnerable groups. However, in Nigeria and most low- and middle-income countries (LMICs), it is the principal modality of health care financing (Olakunde, 2012). Data have shown that out of pocket payment accounted for more than 60% of Nigeria's total health expenditure, putting many households at risk of catastrophic health expenditure, especially those in rural areas and urban slums (Olakunde, 2012; Michael et al., 2019; Uzochukwu et al., 2015). The difficulty experienced by low-income families in paying for health services may partly explain the aggressive behaviour displayed at the service delivery points and may be linked to the difficult midwife -women relationships and workplace violence. This could be related to the fact that due to the catastrophic health expenditure incurred, the women or their relatives may become aggressive at just a little provocation, this may trigger the clients-health providers' difficult relationship or support workplace violence (Aytec et al, 2009).

2.4.3. Social Health Insurance

Social health insurance is a system of financing health care by contributing to an insurance fund that operates according to government rules. The Nigerian social health insurance scheme is called the National Health Insurance Scheme (NHIS). It was established by an act of parliament- Act 35 of 1999 and actualised in 2005 (NHIS, 2020). It was established to increase access to health care and reduce the financial burden of out-of-pocket expenses. Currently, the NHIS principally captures participants in the formal sector, i.e., those working in government parastatals constituting less than 5% of the

population. For the public (Federal) sector programme, the employer pays 3.5% while the employee pays 1.75% of the employee's consolidated salary. For the private sector programme and other government tiers, the employer pays 10% while the employee pays 5%, representing 15% of the employee's basic salary (NHIS 2020). The primary focus of NHIS is the provision of primary health care. Nigeria's strategy of attaining universal health coverage is primarily hinged on creating the basic health care provision fund provided for by the National Health Act of 2014. In this act, one per cent of the government's consolidated revenue has been allocated to the fund in which 50% of the fund should go to the NHIS (Uzochukwu et al., 2015). The informal sector (which constitutes over 90% of the population) of the economy will be covered by the community health insurance contributory scheme - an arm of the NHIS. It is currently being operationalised in several communities in few states of the federation.

The community insurance scheme's biggest challenge is the sustainability of the scheme due to erratic contributions from its participants and the lack of political will on the side of many state governments. Thus, many Nigerians do not currently benefit from a reliable source of health insurance.

2.4.4. Donor Funding

This entails financial assistance given to support socio-economic and health development. In Nigeria, donor funding is meagre, and it is estimated to constitute less than four per cent of the total health expenditure in the last five years (Uzochukwu et al., 2015).

2.5. Free Maternal Health Care in Kaduna State

The Government of Kaduna State introduced a free maternal and child health programme (FMCH) in 2007 as a policy response to reduce maternal and under-fives mortality in all the state's 23 local government areas (MOH 2007). In this scheme, at least 80% of all pregnant women and children under five years of age, including neonates, receive free medical care in all public health facilities in the entire state. This includes antenatal, intrapartum, postnatal services and basic /comprehensive emergency obstetric care and child health services such as prevention and treatment of malaria, respiratory and diarrhoea diseases, febrile illness, growth monitoring and nutritional services.

Furthermore, the state developed and implemented a facility rationalisation plan. Health facilities were grouped into functional clusters, each consisting of a well-equipped referral hospital and several primary health care facilities. Under this arrangement, 25

general/referral hospitals and 510 PHC facilities were rehabilitated and equipped [State Ministry of Health] (SMOH, 2007).

The Free Maternal and Health Care programme heavily depends on the budgetary allocation to it by the Federal Ministry of Health with some ancillary support by development partners. Hence the sustainability of the programme is relatively weak. With the current economic crisis facing Nigeria and, by extension, Kaduna State due to the continuous falling of the international markets' oil prices, funding the programme has become a challenge in recent years (Odupitan, 2017). This may largely contribute to the programme not meeting its set strategic objectives. However, there is general agreement among stakeholders that despite the numerous challenges in implementing the FMCH Programme, it has increased access and utilisation of Free Maternal and Child Health Care services across the state (SAVI 2012). Apart from funding, the other challenges in implementing the FMCH programme include flawed administrative guidelines, poor management of commodity logistics (with frequent stockouts), weak monitoring and evaluation mechanisms, workforce shortage, and weak political will.

2.6. The Nigeria Healthcare Workforce

The healthcare workforce is the key component of every healthcare system without whom health care cannot be delivered to clients and it is also responsible for promoting the health of a given population (Adeloye et al., 2017). The Federal Ministry of Health in Nigeria (FMOH, 2007) reports that one of the major problems facing the Nigerian healthcare system is recruiting and retaining its healthcare workforce. These issues have been largely linked to the skilled worker migration of the Nigerian healthcare workforce (see 2.7) and perhaps lack of motivation among the healthcare workers in some of the health facilities, poor remuneration, poor governance and leadership etc. (Abimbola et al., 2016; Adeloye et al., 2017). Consequently, the country has been reported to be in crisis due to shortages of healthcare workforce (Adeloye et al., 2017; Kuforiji, 2017). Adeloye et al., (2017) also contend that Nigeria's rapidly growing population contributes to its severe health workforce crisis. The total number of the healthcare workforce and the shortages are difficult to ascertain due to the country's inadequate data management system (Adeloye et al., 2017; Kuforiji, 2017). However, the World Health Organisation (2016) reports that Nigeria's health workforce density is estimated at 1.95 per 1000. In 2017, the Nigeria Minister of Health stated that Nigeria had an estimated shortage of 144,000 health workers and ranked second in Africa, Ethiopia was first with an estimated shortage of 152,000. He further noted that the country currently has 240,000 midwives and nurses (Ikumola, 2017). The shortage of the healthcare workforce has been further complicated

by gross inadequacies in the recruitment and distribution of the healthcare workforce within Nigeria's six geopolitical zones (Abimbola et al., 2014). These poor distributions have been linked to poor leadership, planning, and lack of a national policy on human resource management, especially regarding posting and transferring the healthcare workforce (Abimbola et al., 2014; Adeloje et al., 2017). This has led to a healthcare workforce shortage, poor health outcomes, and high maternal mortality rates in Nigeria's regions (Kuforoji, 2017).

2.7. Brain drain/Skilled Worker Migration and the midwifery workforce

Skilled worker migration has been defined as 'the migration of health care professionals in search of educational and professional advancement, higher salaries and better quality of life, often in a stable socio-political environment' (Dodani and LaPorte, 2005, p.487).

Skilled workers migration has been linked to the current health worker crisis in Nigeria due to the migration of highly skilled professionals from Nigeria to HIC, such as the UK, USA, Canada, and Australia (Adeloje et al., 2017). Due to scarcity or lack of health human resource data in Nigeria, accurate figures are difficult to obtain (Adeloje et al., 2017; Kuforoji, 2017). Recently, it was reported that approximately 5,405 Nigerian trained doctors and nurses/midwives were currently working in the National Health Service (NHS) in the United Kingdom (Onyekwere and Egenuka, 2019). Nigerian health professionals constitute about 3.9 per cent of the 137,000 foreign healthcare workforce among the 202 nationalities working in the United Kingdom (Onyekwere and Egenuka, 2019). In the USA, the Migration Policy Institute (2015) revealed that Nigerians form a significant part of the African migrant population in the United States. George and Rhodes (2017) estimated that approximately 376,000 Nigerians were currently working in the United States. Nigeria is ranked among the top 13 African countries that suffer an exodus of its citizens abroad for economic reasons (Onyekwere and Egenuka, 2019). This has made it difficult for the country to achieve its universal health coverage due to a shortage of nurses and midwives (Okoro and Chimereze, 2020). These staff shortages with resultant excess workload have also been reported as sources of workplace adversity impacting on the front-line workers and the quality of care they can provide (Ogu et al., 2017).

There are many causes of skilled migration in Nigeria. Okafor and Chimereze (2020) reported that the increase in nurses and midwives' migration to HIC's is due to some push factors and pull factors. The push factors include poor remuneration, inefficient governmental policies, and poor work environment; on the other hand, the pull factors such as a better work environment and increased incomes believed to be offered by high-

income countries. However, the positive impacts of brain drain, including remittance, improved health and quality of life, are outweighed by nurse/midwife migration's negative impacts (Okafor and Chimereze, 2020). The effect of a skilled worker migration within the healthcare system are extensive, resulting in a shortage of staff with an excess workload, issues around patient safety and quality of care (Kuforiji, 2017). The maternity setting has been affected by the issue of the brain drain in Nigeria. Consequently, an increase in the number of births combined with the continuous migration of skilled maternity care workers, including midwives, may have contributed to the unacceptably high maternal and newborn mortality levels in Nigeria (Kuforiji, 2017). Undoubtedly, maternity care services' provision depends largely on the quality and availability of highly skilled and compassionate healthcare workers, including midwives. Maternity care provided by midwives who are educated and regulated according to global professional standards is a critical strategy for reducing two-thirds of all maternal and infant deaths, thereby improving sexual and reproductive, maternal, newborn and adolescent health (Homer et al., 2014; Renfrew et al., 2014; UNFPA, ICM and WHO, 2021).

Okafor and Chimereze (2020) pointed out that with the continuous exodus of skilled health workers, the government must provide appropriate measures to reduce Nigerian nurses/midwives' migration to high-income countries. These may include an increased income, better work environment, professional autonomy, and better policies on migration.

2.8. Maternal Health Care Services and Midwifery Workforce in Nigeria

Maternal health care services refer to a range of health services provided to mothers before and during pregnancy, at childbirth, and during the postnatal period (Olanade et al., 2019). The improved outcome of this care depends on the quality and quantity of the workforce providing these services (Adegoke et al., 2013). A good strategy for achieving these better outcomes is using skilled birth attendants consisting of the professional birth attendant (Adegoke et al., 2013). The WHO (2006) defines a skilled birth attendant as an accredited health professional, a midwife, a nurse or a doctor with midwifery skills.

Midwives have been identified as the key professionals needed to reduce maternal mortality globally (WHO, 2006; Adegoke et al., 2013). In Nigeria there are a total of eight different cadres of health care workers providing maternity care services: midwives, nurses, nurse-midwives, doctors, obstetricians, community health officers, community health extension workers and junior community health workers (Adegoke et al., 2015). Maternity care services are provided across the three levels of care in Nigeria. The primary health care facility provides essential obstetric care services for women living

within the community (Labiran et al., 2008). The cadres of staff mandated to work in primary health care centres are community health officer, general nurse, midwife, nurse-midwife, public health nurses, community health extension worker, and junior community health extension worker (Adegoke et al., 2013). The community health officer is senior and co-ordinates the activities of the primary health care centre. The cadres are expected to provide services based on their level of competence. The community health officers usually send a referral letter to the next level of care (Nkwo et al., 2015). The community health extension workers in Nigeria train for three years and are then qualified to provide essential services in primary health care centres (Adegoke et al., 2013). The junior community health extension worker trains for two and a half years in the same competencies as the community health extension worker (Nkwo et al., 2015) and is then expected to assist the community health extension workers. Adegoke et al. (2013) further revealed that both categories of community extension workers are officially referred to as community extension workers. Neither have any competency-based midwifery training (Adegoke et al., 2013) and are not considered skill birth attendants. However, their income at the commencement of work is different (Nkwo et al., 2015). Nkwo et al's study (2015) further showed that primary health care facilities are staffed by many of these community extension workers. This may be due to the fact that they are trained initially to remain in primary health care centres and are not prepared for midwifery proficiency (ICM, 2010). They are therefore not considered as skilled birth (attendants' (Nkwo et al., 2015) and for this reason they have limited employment opportunities and a lower salary. Consequently, these substitute health workers accept postings to rural areas where other globally recognised health workers such as doctors, nurse and midwives would not (Nkwo et al., 2015).

Conversely general nurses are usually direct from secondary school and are trained for three years during which time they focus on general nursing care (FMOH, 2004; Nkwo et al., 2015). This is similar to adult nurse training in the UK. The public health nurses are also trained as general nurses, but the focus is on disease prevention and health promotion (Nkwo et al., 2015). For midwifery training, there are various routes provided for competency-based midwifery training (See 2.9).

The secondary care facility provides comprehensive obstetric care services, these include emergency caesarean section and blood transfusion services (Labiran et al., 2008). The nurses, midwives, nurse-midwives, physicians and obstetricians provide care at this level. Meanwhile, the tertiary care institution provides intensive care services in the intensive unit with other services provided in secondary care institutions (Abimbola et al., 2012). It has a similar cadre of staff with specialist and consultant in different fields of medicine and

nursing. A referral system exists, this transfers care across each level to enhance the quality of care rendered. This is achieved by giving a written referral note to the patient, this describes the care provided prior to referral to the next higher care level.

Table 2. 1: Cadre of staff providing maternity care in the tiers of care

Serial No.	Tiers or Level of Care	Cadre of Health Workers	Maternity services provided
1	Primary Health Care	Community health officers, community health extension workers, nurses, midwives, nurse-midwives	Antenatal, intrapartum and postnatal care, basic emergency obstetric and neonatal care, child welfare services
2	Secondary	Nurses, midwives, nurse-midwives, physicians, obstetricians	Comprehensive emergency obstetric care including operative delivery and blood transfusion
3	Tertiary	Nurse-midwives, resident doctors and obstetricians	As in 2 above, plus intensive care and rehabilitative services

2.9. Nursing and midwifery training in Nigeria

Nursing and midwifery training takes place across all the six geographical regions of Nigeria. There are 262 nursing and midwifery schools in Nigeria (NMCN, 2020) including 47 schools of basic midwifery, 37 schools of post-basic midwifery and 28 departments of nursing across the country providing midwifery training (NMCN,2020).

There are various forms of midwifery training in Nigeria. Firstly, a general nurse may undergo an 18-month additional training on competency-based midwifery to qualify as a registered midwife (Adegoke et al., 2013). Also, the single qualified nurse may proceed to the second year of a BNSc programme where she qualifies to sit the final midwifery exams at the end of training. The midwife is then designated as a nurse/midwife to reflect her double qualification as both a nurse and a midwife. After qualifying as a general nurse,

such midwifery training is regarded as a 'post-basic' midwifery training to differentiate it from the basic midwifery training. The second route, also referred to as 'basic' midwifery training, it consists of students recruited directly from secondary school with no previous nursing qualification (Oyetunde and Nwonta, 2013). This training is usually for three years. A single qualified midwife would have completed the three-year basic midwifery programme (Oyetunde and Nwonta, 2013). In contrast, a nurse-midwife is expected to have completed an eighteen (18) month midwifery course or a BNSc degree programme, in addition to her nursing training of about three years (Oyetunde and Nwonta, 2013).

Basic midwifery training has been initiated in several parts of Nigeria within the last ten years, it has produced midwives who practise mainly in primary health care settings (Nkwo et al, 2015). The 3-year basic midwifery programme was introduced in 2003 by the Nursing and Midwifery Council of Nigeria to allow students to train as midwives without first obtaining a nursing qualification and 17 out of the 36 states decided to run the programme in 22 schools (Oyetunde and Nwonta, 2013). After completing the basic programme, midwives can move into practice directly or proceed with further education by undertaking an 18-month general nursing training programme (Oyetunde and Nwonta, 2013). They can also proceed to the second year of a five-year BNSc degree to qualify to sit the registered nurses' final exams. Students are expected to pass written, oral and practical examinations before being awarded their degrees (Kuforiji, 2017).

2.10. Maternal Mortality, Sustainable Development Goals and this study

Pregnancy and childbirth complications are among the leading causes of death and disability among women of reproductive age in Nigeria (Okonofua et al., 2018). In 2017, an estimated 295,000 maternal deaths occurred globally due to pregnancy and childbirth complications, out of which sub-Saharan Africa and Southern Asia accounted for approximately 86% (254,000) of the estimated global maternal deaths (WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division, 2019). At the country level, two countries had the highest estimated numbers of maternal deaths, accounting for a third (35%) of the global maternal deaths: Nigeria at 23% (67,000) and India at 12% (35,000) (WHO, UNFPA, UNICEF and World Bank, 2019). While Nigeria represents approximately 2.6% of the global population, it records 23% of global maternal deaths (NDHS, 2018).

Maternal mortality has been defined differently by different authors. The World Health Organisation (2005) defines maternal mortality as: 'the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of

pregnancy from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes' (WHO, 2005, p.11). Also, the Nigeria Demographic and Health Survey (NDHS, 2018) defines 'maternal mortality as deaths of women during pregnancy, birth, within 42 days after delivery, excluding deaths due to violence and accidents' (NDHS, 2018. p.64). This definition means that if the death of a woman is related to pregnancy and childbirth, excluding other external causes, it is classified as a maternal death. The maternal mortality ratio (MMR) for Nigeria is 512 deaths per 100,000 live births (NDHS, 2018). Simultaneously, the neonatal and infant mortality rates were 39 and 67 per 1000 live births, respectively (NDHS, 2018). The leading causes of maternal mortality are haemorrhage, infection, pre-eclampsia/eclampsia, obstructed labour, and unsafe abortions (WHO, 2019). Other indirect causes include malaria, HIV/AIDS, anaemia and cardiovascular diseases complicating pregnancy or worsening it. Also, the lack of adequately trained health workers may increase women's chances of dying from these conditions (Say et al., 2014; Ogu et al., 2017; WHO, 2019). According to NDHS (2018), 36% of births in Nigeria take place in health facilities. Some 23% occur in public sector facilities, 13% in private facilities and 63% at home, specifically in rural communities. This high percentage of home births without a skilled birth attendant may be connected to Nigeria's high maternal and infant mortality rates. Other related causes of maternal death include poverty, ignorance, and health workers' attitudes all of which may influence their facility-based birth choice. (Ogu et al., 2017).

Furthermore, three degrees of delays have been associated with maternal deaths (Thaddeus and Maine, 1994). The first-degree delay is the decision-making of the woman and her family in seeking medical help. This is principally dependent on the client and family's reproductive health-seeking behaviour, linked to the family's socioeconomic status and the cultural environment. The second degree defines the ease of accessibility to health facilities within the community. This is dependent on the transport infrastructure available. The delay in getting care in the health facility is referred to as the third-degree delay (Garba and Umar, 2013). This is related to the quality of care of maternal and child health services provided. In Nigeria, most maternal deaths are associated with combinations of these delays (Garba and Umar, 2013). These delays are also known as determinants of maternal mortality. This constant high rate of maternal and child mortality in Nigeria hindered the achievement of the Millennium Development Goals (MDGs 4 and 5). Despite the efforts made by the Government of Nigeria only a slight reduction was achieved, this was insufficient to meet the targets for MDG 4 and 5 (UNDP, 2010).

In 2015, the MDGs were replaced by a transformative 2030 plan for Sustainable Development (UNDP, 2015). This plan has 17 Sustainable Development Goals with 169 targets to be achieved over the next nine years (see Appendix A). As a sequel to MDG 4 and 5, SDG 3 focuses on 'ensuring healthy lives, promoting well-being at all ages with 3.1 targeted towards reducing maternal mortality to 70 per 100,000 live births and 3.2 aimed at reducing neonatal and under five mortality rates.

Due to the international focus on achieving Sustainable Development Goal 3 and a national focus on reducing Nigeria's unacceptable maternal mortality level, it is important to research maternity care, especially in the workforce space (UNDP 2015; NDHS, 2018). Thus, this study's findings and recommendations could improve policy and help achieve some of the targets of SDG 3.1, 3.2 and 3C. Specifically related to this study is goal 3C, this focuses on '...the recruitment, development, training and retention of the health workforce in developing countries' (UN 2015, p. 17). Resilient strategies and theory designed from this study may help midwives provide compassionate care to mothers, which may increase access to skilled birth attendance and may invariably lead to a reduction in maternal and infant deaths. It may also promote retention of the midwifery workforce in Nigeria and other LMICs.

2.11. Summary

In summary, this chapter presented an overview of Nigeria and its demographic characteristics and the Nigerian healthcare system. It also described the various ways of financing health care in Nigeria and provided an overview of the state's free maternal and child health policy. The concept of brain drain its causes and impact on the healthcare system and quality of care were also discussed. An overview of the maternity care workforce and nursing and midwifery training was presented before considering the United Nations SDGs and their relevance to this study. Chapter Three will present the literature review, this provides the critical examination and meaning of workplace adversity and resilience among midwives and the importance of this study in Nigeria and other LMICs.

CHAPTER THREE - Literature review

3.1. Introduction

This chapter reviews available literature relating to workplace adversity and resilience among midwives globally. It presents a narrative review conducted systematically. The chapter begins with an overview of the use of literature in a grounded theory study before describing the search strategy used to identify the literature review articles.

The literature reviewed examines workplace adversity and resilience among midwives and in relation to maternity services. However, the literature on workplace adversity in maternity settings was limited and very little was from a Nigerian perspective. The literature on midwifery resilience was also significantly limited globally. Furthermore, there were challenges in reviewing the existing evidence because in some LMICs, including Nigeria, most midwives were double qualified but referred to as nurses; only a few studies were clear about the participants being midwives. Also, some of the studies used workplace adversity and stress interchangeably and stress was conflated as workplace adversity, whereas stress is an actual response to workplace adversity. Due to this limitation, I have drawn from the literature around nursing and the health care workforce where appropriate and referred to the few studies about midwifery where available. The literature reviewed presents the causes and perceived effects and response to workplace adversity, the meaning of resilience, and other health professionals' various resilient strategies. This chapter concludes with a summary of the articles reviewed.

3.2. Use of Literature in Grounded Theory

Traditionally, grounded theorists discourage undertaking a literature review prior to data collection. Rather, researchers are encouraged to go into data collection as a *tabula rasa* or in a blank state (Reigher, 2019). Glaser opined that “there is a need not to review any of the literature in the substantive area under study” (Glaser, 1992, p.31) to prevent data from being generated through a “contaminated lens” of earlier ideas, thereby forcing data into pre-existing categories (Charmaz, 2014, p.134.). However, the Straussian grounded theory research takes a different position in using literature in grounded theory as it advocates for the use of an early literature review. (Corbin and Strauss, 2008; Strauss, 1987). Breckenridge and Jones (2009) asserted that “pre-existing knowledge can guide the researcher in identifying a starting point for data collection, but this knowledge should be awarded no relevance until validated or dismissed by the formulation of the emerging theory” (Breckenridge and Jones, 2009, p.119). Additionally, McGhee et al. (2007) stated

that the “use of literature or any other pre-knowledge should not prevent a grounded theory arising from the inductive – deductive interplay which is at the heart of this method” (McGhee et., 2007, p. 334). Furthermore, the authors assert that bias and subjectivity associated with grounded theory methods can be prevented by considering reflexivity as a “consciously reflective process” which should be utilised judiciously all through the process of data collection and analysis (McGhee et al., 2007. p.335). Using memos can also strengthen the researcher's reflexivity by maintaining self-awareness of all incidents throughout data collection and analysis (Charmaz, 2014).

Practically, avoiding a review of the literature may be impossible, particularly for PhD students. An initial research proposal is mandatory before securing admission to a PhD programme and for ethical approval prior to data collection. Both processes need at least an initial brief literature review. A literature review is also necessary to meet most institutional review boards (Corbin and Strauss, 2008). There are also benefits associated with an initial literature review. Firstly, a literature search helps to orientate the researcher, this ultimately helps inform the development of research questions before data collection commencement (Charmaz, 2014). Secondly, a literature review also shows a gap in knowledge around the topic and confirms that the current study is needed to add new knowledge to the area of interest. Also, while formulating a topic, there may be a need to familiarise oneself with literature as a PhD is needed to fill in a gap in an area or contribute to a particular body of knowledge. Additionally, progression through a PhD programme requires that a literature review be undertaken. Thus, the use of a literature review may be non-negotiable for a PhD student.

In this study, the Charmaz (2014) constructivist grounded theory approach was used. A ‘middle of the road’ stance was adopted that is not entirely against using the literature as the literature review was used to sensitise and guide the researcher around the research topic. The topic was chosen whilst undertaking a search on midwives' workplace adversity and coping skills. When considering Nigeria's maternal mortality, it was interesting to look at ways in which Nigerian midwives might be supported, motivated and cared for so that they could be more compassionate when caring for women under their care. Macdonald's et al work (2011) and Hunter and Warren (2014) greatly informed the proposal for this PhD submission. A literature review was presented to the Cardiff University School of Healthcare Sciences Ethical Review Board and the Ethics Committees of Nigeria's study areas. For these reasons, an initial brief search and review was conducted whilst the proposal was being written, this was returned to in-depth following data analysis. The literature review was also valuable in selecting theoretical samples and enhanced theoretical sensitivity during data collection and analysis. Reflexivity was useful in

reducing bias and for minimising the impact of my personal and professional experience on the data and the generated theory. An in-depth literature review chapter was written after the data collection and analysis, specific literature focused on the codes generated from the data. The inclusion of a preliminary literature review was the primary reason for choosing a constructivist grounded theory.

3.3. Search Strategy

The literature review aimed to explore current literature related to workplace adversity and resilience, to identify the gap in the body of knowledge, investigate further and possibly fill the identified gap. An early search was conducted between January and March 2016 in order to develop an initial research aim and questions prior to commencement of the PhD study. Using the tenets of constructivist grounded theory, an in-depth search was conducted in September 2020, this focused on the codes generated after data analysis. The literature review chapter was based on the final search and was merged with the initial literature. The search was comprehensive and covered all the possible terms that were important to the study's aim. The search focused on the following three concepts: midwives, workplace adversity and resilience. Initially, the search included nurses, this generated an overwhelming hit but was later restricted to midwives, nurse-midwives, and health professionals. The concepts and the associated search terms can be seen in Table 3.1. The search was supported by the help of a School of Healthcare subject library technician.

An in-depth electronic systematic search was conducted across Cumulative Index for Nursing Allied Health Literature (CINAHL), Medline via Ovid, and Psych info; other sources included textbooks and back chaining through different articles and grey literature. Websites such as the Health and Safety Executive, World Health Organisation, the Nigerian Federal Ministry of Health and the Kaduna State Ministry of Health were also used to source information. The search was limited to papers written in English with no geographic limitation applied initially, then LMICs, and finally developing countries. Boolean operators were used to identify relevant literature. The exact terms were used across all databases. The titles and abstracts of retrieved articles were assessed. The full text of all articles selected, based on their title and abstract, were retrieved. A decision was then taken regarding its relevance to the study based on the objectives. All the identified literature was reviewed irrespective of the research methodologies used. The search was narrowed by using inclusion and exclusion criteria (see Table 3.3.1). The literature review included articles published from 2005 to 2020 in peer-reviewed journals and grey literature such as dissertations and theses.

The retrieved articles' abstracts were checked against the inclusion criteria to ensure that the most relevant and current studies were selected. Fifty-nine papers were retrieved, other articles and grey literature were obtained from backward chaining to ensure no articles were left out. All selected articles were read, and findings were grouped into themes: the concept of workplace stress in nursing and midwifery context; causes of workplace adversity which included: a shortage of workforce, a high workload, shortage of human resources, poor collegial relationship, attending to a traumatic birth. Other themes included the perceived impact of workplace stress, the concept of resilience, resilience in nursing, resilience in midwifery. These informed the literature review.

Table 3. 1: Showing Key terms used for search strategy

Key terms	Midwife	Resilience	Low* income count*
	Midwi*	Hardiness	Developing countries
	Healthcare	Workplace*	Middle income
	Professional	adversit*	count*
	Nurse-midwife	Stress*	Sub-Saharan Africa
		Burnout*	
		Professional	
		Burn*out*	
		Coping	
		Resilien*	
		Professional resilien*	

Table 3. 2: Inclusion and exclusion criteria

Inclusion Criteria	Exclusion Criteria
Primary research studies	Studies not published in English language
Literature reviews	Articles that looked at stress and burnout among student midwives
Policies and official reports	Articles that focused on resilience among student nurses and student midwives
Articles and grey literature published in English between 2005 to 2020	
Grey Literature from theses and dissertations	
Research articles that focused on resilience	
Workplace adversity, stress or resilience among midwives and nurse-midwives	
References focusing on nurses and midwives' resilience	
Studies that looked at coping strategies and hardiness.	

3.4. An overview of the literature review on workplace adversity in the nursing and midwifery context

This section presents a general overview of the concept of workplace adversity in the nursing and midwifery context. The subsequent paragraph explains the causes of adversity; the commonest causes were described for the purpose of this literature review. Then the concept of resilience, resilience in nursing and midwifery and it closes with a summary of the literature review.

Workplace adversity is a phenomenon attracting global attention in nursing and midwifery literature. This is not surprising, as nurses' and midwives' workplaces have become more exigent (Glass, 2009). Jackson et al. (2007) defined workplace adversity as an aggregate of adverse occupational conditions and events that predisposes to hardship, stress, and burnout. Tugade and Fredriksson (2004) also define adversity as a state of suffering resulting from trauma, misfortune, distress or a tragic event. Evidence suggests that

health professionals are at higher risk from the adverse effects of working in stressful workplaces, including the maternity care setting (Edwards et al., 2000; Kirkcaldy and Martin, 2000; Mark and Smith, 2012; Rouleau et al., 2012; Creedy et al., 2017; Harvie et al., 2019). Healthcare workers are particularly at risk of experiencing workplace adversity leading to stress and burnout due to continuous exposure to stressors, high absenteeism and staff turnover (Harvie et al., 2019; Suleiman-Martos et al., 2020).

Midwifery has been described as an emotionally charged profession (Hunter, 2001; Hunter, 2004; Hunter and Warren, 2014). Whether a woman's pregnancy and childbirth experience is positive or negative (fetal demise or maternal death) midwives are involved in caring for them and their families. Studies of the emotional work required to achieve the necessary midwifery outcomes revealed that this might be costly for the midwife's psychological well-being (Hunter, 2001; Hunter and Deery, 2004; Mann, 2004; Leinweber and Rowe, 2010; Mollart et al., 2013). A study by Hunter and Deery (2005) found that midwives considered working with women to be highly emotional, they felt that this aspect of midwifery work was unacknowledged and undervalued by their professional colleagues and the hospital system in which they worked. Additionally, the 'cost of caring' concept has attracted much attention in the literature, it has been described as 'vicarious traumatization', 'compassion fatigue', 'post-traumatic stress disorder' and 'secondary traumatic stress disorder' (Dominguez-Gomez and Rutledge, 2009; Leinweber and Rowe, 2010; Mollart et al., 2011). The cost ranges from minor increases in stress to major symptoms affecting mental health and the inability to provide quality care (Mollart et al., 2009; Halperin et al., 2011).

3.4.1. Causes of workplace adversity among nurses and midwives in maternity units.

Workplace adversity presents itself in different forms. For example, in a UK study, midwives reported an imbalance between the professional ideal of being 'with woman' (providing woman-centred care) and the reality of working in a busy workplace environment where the needs of the institution were perceived to take precedence (Hunter, 2004). This conflict of ideologies creates dissonance and may contribute to workplace adversity and a decision to leave the profession. Current midwifery evidence from around the world describes adverse work situations such as excess workload, staff shortage, a poor work environment with a general lack of essential resources, unsupportive colleagues and attending to a traumatic birth as potential causes of stress and burnout (Thorsen et al., 2011; Macdonald, 2010; Rouleau et al., 2012; Rice and Warland, 2013; Anyebe et al., 2014; Banovcinova and Baskova, 2014; Ladan et al., 2014;

Mullira and Ssendikadiwa, 2016, Barde, et al. 2017, Creedy et al. 2017, Geraghty, 2018; Hunter et al., 2019; Suleiman-Martos et al. 2020). However, factors contributing to workplace adversity which may lead to stress in midwifery vary greatly based on the availability of resources, structure and the composition of the health care system, culture, speciality, education, and healthcare workers' work experience (Wright et al., 2017). The following review of workplace adversity literature focuses on the leading causes of workplace adversity: severe staff shortage resulting in an extreme workload, resource constraints, relational challenges, and attending to a traumatic birth. Most of these stressors were found to be influenced by one another. These are discussed in the following paragraphs.

3.4.1.1. Shortage of workforce, excess workload and resource constraints

The issues of staff shortage, excess workload, and resources are global, but have different effects in HICs and in LMICs. For example, Knezevic et al., (2011) conducted a study in Croatia, it explored the sources and levels of work-related stress amongst Croatian midwives using a cross-sectional design. The participants included 105 registered midwives, and 195 paediatric nurses surveyed using a validated tool Occupational Stress Assessment Questionnaire (OSAQ). The midwife participants represented 14.7% of all hospital-based midwives in Zagreb hospitals. Seventy-seven percent of midwives stated that insufficient work resources and poor work organisation were the primary source of stress. While over 50% of the midwives identified a shortage of staff, unexpected situations, and poor organisation at work as being highly stressful (Knezevic et al., 2011). However, the study did not explore burnout, job satisfaction and emotional well-being among the participants. Thus, it appears that the knowledge provided by the survey was relatively superficial. Despite that, it provides an insight into the causes of workplace stress among midwives in a high-income country.

Similarly, in Japan, some researchers (Sato and Adachie, 2013) used a cross-sectional descriptive study to examine stress among Japanese midwives. The study found that 80 – 90% of midwives in Japan are highly stressed by an excess workload. (Sato and Adachie, 2013). This may be linked to the fact that the midwives were at a higher risk of stress than other healthcare professionals, (Pezaro et al., 2016) due to their job's emotionally demanding nature (Hunter, 2001; Hunter and Warren, 2014).

Furthermore, the study by Macdonald (2011) revealed the following causes of workplace adversity among nurses and midwives: poor working conditions, extended hours, poor staff support, heavy workloads, high physical demand, workplace bullying and aggression. However, this study did not distinguish between the nurses' or midwives' experiences of

workplace adversity. But some of the adversity experienced by the participants was similar to that reported by midwives in other studies. For example, staff shortages, excess workload, workplace bullying (Ball et al., 2002; Kirkham et al., 2006; Mollart et al., 2011). It could generally be considered that the midwives were more at risk because of the nature of their profession as described by other studies (Hunter, 2001; Hunter and Warren, 2014). Hunter and Warren (2014) also found that workplace adversity was a common experience among midwives. The workplace created stressful situations over which midwives felt they had little or no control. The respondents' common stressor was an excessive workload and paperwork resulting in staff shortages and the inability to take breaks.

Additionally, a survey of members (n= 2,716) by the UK Royal College of Midwives (RCM, 2016) exploring why midwives left the profession concluded that workplace adversity resulting from poor staff level, workload, inadequate support from managers, and poor working conditions were the most frequently cited reasons (RCM, 2016). Also, for those midwives considering leaving, the five top reasons identified were: poor staffing levels at work (62%); not satisfied with the quality of care they were able to give (52%); excessive workload (46%), poor working conditions (37%), dissatisfaction with the model of care they were working in (30%).

The five above mentioned reasons are surely evidence of the manifestation of workplace adversity in the work environment (RCM, 2016). One of the study's limitations was the lack of a qualitative component that would have provided a more in-depth insight into the situation. Additionally, the sample size was relatively small; thus, generalisability should be treated with caution. However, the findings gave an insight into the factors influencing midwives' decisions to leave.

In Australia, Geraghty (2017) used the Straussian grounded theory methodology to explore work-related stress among twenty-one midwife participants. The midwives in the study compared 'workloads' as a difficult battle while providing care for women and babies. The study concluded that work-related stress affected midwives' future decisions to remain in midwifery (Geraghty, 2017) and developed a grounded theory of midwives' workplace stress. However, the study did not describe the resilient strategies the midwives used to deal with the workplace stressors, which would have provided further insights. This study may be similar to the current research, as it also explored the causes of workplace adversity among midwives in a labour ward. However, the applicability of the findings should be treated with caution as Australia is a HIC while the current study area is in LMIC, so the level of adversity may differ from the present study due to the structure of the health care system.

Workplace factors were also identified as sources of stress and depression in a recent study in the UK. The WHELM study by Hunter et al. (2019) used a cross-sectional descriptive survey to explore the relationship between UK midwives' emotional well-being and their work environment. The study found that several demographic and work-related factors were associated with high levels of burnout, depression, anxiety and stress, including age, length of experience and clinical role. Poor emotional health was more common amongst younger participants and those with fewer years of clinical experience. The study concluded that improving midwives' well-being is crucial for recruitment and retention in order to enhance maternal and child services. However, the response rate appears small, with 1,997 midwives responding to the survey, representing 16% of the RCM membership, this may limit generalisation. Despite that, the findings gave important insights into which workplace factors were most likely to result in stress and burnout and identified which midwives might be most vulnerable.

As a sequel to the WHELM study Hunter et al., (2019), Cull et al. (2020) explored newly qualified UK midwives' emotional health and their work environment by analysing the qualitative data from the WHELM study. Of the 1,997 survey respondents, 620 midwives were qualified for five years or less, this represented 31% of the study sample. It was the data from these midwives that were analysed. Findings from the study revealed that most newly qualified midwives were exposed to extreme workplace pressure resulting from staff shortages and an overwhelming workload. These findings confirmed workload and staff shortages as a source of workplace adversity in a HIC (Cull et al., 2020). Excessive workloads and staff shortages were also identified as a source of workplace adversity for midwives in HIC in two qualitative studies: Hunter and Warren (2014) in the United Kingdom and Macdonald (2011) in Australia.

A literature review by Cramer and Hunter (2019) aimed to investigate the association between midwives' emotional well-being and their working conditions, it found that an excess workload was associated with emotional distress in midwives. Additionally, dealing with a high workload was found in a study of newly qualified midwives in Australia, who described staffing problems as making conditions' "diabolical" (Fenwick et al., 2012).

Furthermore, high workload has also been linked to the reason why midwives left their profession. For example, more than a decade ago, a study of midwives by Curtis et al. (2006) was conducted in two phases using interviews (n=28) and questionnaires (n=978) to explore why midwives left the profession. Curtis et al. (2006) identified workplace adversity as a critical factor that impacted on midwives' physical and mental health and contributed to their decision to leave midwifery. The significant sources of stress amongst

the participants were staff shortages, high work demands, lack of control, lack of support and inability to practise the midwifery they wanted (job dissatisfaction) (Curtis et al., 2006). These findings were supported by Deery (2005), whose earlier study of UK midwives also found evidence of occupational stress and burnout. The evidence from all the studies referred to in this section suggests that midwives in many countries experience workplace adversity due to high workloads and staff shortages. This leads to stress and burnout which may result in poor retention of midwives. However, not all midwives respond in this way. It may be that some midwives develop resilience in order to remain in the profession. The concept of resilience is explored later in this chapter.

The evidence relating to workplace adversity in maternity care in LMICs is limited. In Nigeria, 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. These studies were conducted with nurses, none were carried out specifically within the maternity setting although some studies included midwives who were double qualified but classified as nurses even if they were working in the maternity setting. The studies reported high prevalence of occupational stress and emphasised the link between workplace stress and burnout (Lasebikan and Oyetunde, 2012; Anyebe et al., 2014; Ladan et al., 2014). Therefore, to effectively manage the levels of stress experienced by midwives', causes of workplace adversity need to be explored in-depth, specifically in the maternity care setting in Nigeria and other LMICs.

Some of the causes of workplace adversity echo findings from the WHO (2016) Midwives Voices and Midwives Realities study, a global consultation with 2,470 midwives in 93 LMICs, including Nigeria. This study aimed to explore barriers to providing high-quality, respectful care for women, newborns, and their families in LMICs. The professional barriers to the provision of quality midwifery care were identified, midwives experienced difficult work situations due to heavy workloads and staff shortage. They also lacked sufficient competence to manage work tasks autonomously which made them feel frustrated and demotivated. These factors might have contributed to workplace adversity and burnout, impacted on the provision of quality midwifery care, and eventually influenced their decision to leave the profession (Filby et al., 2017). This phenomenon is not limited to LMICs and is also prevalent in some other HIC, though the severity of the problem may differ due to other factors (Wright et al., 2018).

In Nigeria, Lasebikan and Oyetunde (2012) conducted a quantitative survey among nurses (n=270) in the Southwest region of the country, this survey aimed to evaluate the

prevalence of stress and factors associated with burnout in a general hospital using a validated tool (i.e. a general health questionnaire). Findings from this study reported a high incidence of occupational stress-related burnout among nurses resulting from a shortage of staff with many patients to cater for. One of the limitations of this study was that it was conducted in one facility, hence generalisation can only be made with caution. Also, even if nurses in Nigeria are mostly double qualified, the study did not clearly state the particular unit the nurses were selected from. Perhaps if in the maternity ward, one could consider the nurses as midwives. Despite this limitation, the study provided information on the causes of workplace stress among nurses in Nigeria.

In 2014, researchers in the North-western region in Nigeria, (Anyebe et al., 2014) used a cross-sectional descriptive study to examine the prevalence and causes of stress among nurses (n= 273) working in tertiary and secondary healthcare hospitals using a self-administered questionnaire. The findings revealed that the causes of stress among nurses were similar to those mentioned in earlier studies: a shortage of staff, heavy workload and a lack of adequate equipment. In the same year, Ladan et al., (2014) conducted research using a wide range of healthcare professionals in Northwest Nigeria (n=107), including 45 nurses/midwives, 48 doctors, 5 pharmacists, 3 physiotherapists and 6 medical lab scientists. The authors reported similar findings to other studies, these included staff shortages, heavy workload, long working hours and poor communication with colleagues as some of the major stressors. The sample sizes of these studies were small so generalisability should be treated with caution. Also, it was not clear whether the instrument used was a validated tool. Despite that, the study provided information on the causes of stress among nurses and perhaps midwives in North-western Nigeria.

However, studies of workplace adversity specifically among midwives working within maternity in Nigeria are non-existent, there is also a paucity of literature on how midwives withstand adversity by demonstrating resilience in Nigeria and other LMICs. Thus, the current study would build on these studies describing midwives' workplace and their resilience in Nigeria.

The issue of staff shortages and workloads has also been confirmed by women using tertiary health institutions in Nigeria. For example, Ogu et al. (2017) used a qualitative design to explore women's perceptions of maternal health care providers' workload and its effect on maternal healthcare delivery in secondary and tertiary hospitals in Nigeria. Five focus group discussions were conducted with women in each of the eight secondary and tertiary hospitals in eight states of the country's four geopolitical zones. A total of 40 focus groups were held with women attending antenatal and postnatal clinics in the hospitals. Most women confirmed that health providers felt overwhelmed by their heavy workloads.

(Ogu et al., 2017). Some of the evidence of heavy workload cited included complaints from health providers, evidence of stress by providers while providing care to mothers and a visibly high number of unattended patients. The resultant prolonged waiting time experienced by women when accessing care was considered to be a consequence of heavy workload. This resulted in women's unwillingness to access maternity care due to the perception that there would be long waiting time. This study concluded that women were concerned about the heavy workloads experienced by healthcare providers and that this may be linked to low utilisation of referral health facilities for maternal health care in Nigeria (Ogu et al., 2017). However, the women in the study did not only refer to midwives alone but also to all maternity care providers. Ogu et al. (2017), therefore provide insight into workload as a major source of stress to maternity staff, including midwives and its impact on maternity care services and women's experiences of care in Northern Nigeria.

Besides heavy workload, a lack of resources was also found to be a cause of workplace adversity which further compounded the midwives' problem in their workplace (Anyebe et al., 2014; Ladan et al., 2014). Filby et al. (2017) and Munabi-Babigumira et al. (2018) both conducted systematic reviews which revealed that poor working conditions and insufficient basic resources such as inadequate water supply, basic sanitation, drugs and equipment could compromise the quality of care provided to mothers and their babies.

Similar findings were consistent with the few studies conducted in Nigeria among nurses and other health care workers (Effionm et al., 2007; Anyebe et al., 2014; Ladan et al., 2014; John et al., 2015). These studies also identified a lack of availability of basic resources, faulty equipment, and inadequate supplies in government hospitals as major stressors among nurses.

Furthermore, researchers (Adolphus et al, 2016) conducted a qualitative study in Mozambique to explore midwives' experiences of working conditions. The nine semi-structured interviews and one follow-up interview were analysed using qualitative content analysis. The study results revealed two main themes: commitment/devotion and lack of resources. Working alone under challenging conditions, a lack of staff and material resources along with a weak referral system created much frustration for the midwives. The lack of resources prevented the midwives from providing quality care and created frustration and feelings of inadequacy (Adolphus et al., 2016). This combined with the job's emotionally challenging nature may increase the adversity experienced by the midwives.

In 2020, researchers in the Democratic Republic of Congo (DRC) (Bogren et al., 2020) conducted a qualitative study to explore the challenges and factors that motivate

midwives' retention in the workplace. Data were collected in two out of 26 provinces in the DRC through ten focus group discussions with 63 midwives working at ten different healthcare facilities. The data were inductively analysed using content analysis. Some of the findings revealed the midwives' challenges at their workplace. A general lack of resources and equipment, including space, basic essential clinical equipment for labour and birth, shortage of electricity, and birthing beds were among the major source of workplace adversity. These factors served as a source of constant frustration and a great challenge for the provision of care. The study concluded that a strong professional conscience drives the midwives in the DRC to provide care of high quality despite a difficult work environment and low professional status. This study provides a means of understanding some of the difficulties faced by midwives in LMICs and how a lack of basic resources contributes to adversity in the workplace. One of the study's limitations was that using focus group discussions alone could hinder freedom of speech and other personal information and may influence the quality of data generated. Despite that, the findings contribute to the body of knowledge on the causes of workplace adversity in midwifery, especially in a LMIC, which may influence midwives' retention in their workplace.

Lack of resources has also been reported by other studies as a source of adversity for nurses and health workers in other HICs and LMICs (Glazer and Gyurak, 2008; Jones, 2014; Adib-Hajbaghery et al., 2012; Mosadeghrad, 2013; Kpessague and Soedie, 2017; O'Dowd et al., 2018; Manyisa and Aswegen, 2017). It can be concluded that irrespective of regional or geographical differences, lack of resources and inadequate resources created a stressful working environment for healthcare staff. However, the severity of these challenges may vary considerably between countries.

3.4.1.2. Poor collegial relationships

The issue of poor collegial relationships as a source of workplace adversity has been documented in both HICs in midwifery settings (Macdonald, 2010; Hunter and Warren, 2014; Cull, et al., 2020; Mbattude et al., 2020) and among nurses in LMICs in hospital settings (Mojoyinola, 2008; Ladan et al., 2014; Anyebe et al., 2014).

Cull et al. (2020) reported that many midwives in their UK study emphasised negative working relationships with colleagues as a source of stress and dissatisfaction. It also corroborates with Macdonald's (2011) research and Geraghty (2018) in Australia, which revealed poor staff support, poor working relations, and role overload, among others, as a cause of workplace adversity. These findings were also not new among midwives in other low and middle-income countries (Bakibingi et al., 2012; Mbatunde et al., 2020). For instance, in Uganda, Bakibinga and colleagues (2012) reported that the nurses and

midwives declared dealing with unsupportive colleagues as “serious stressors”. They also reported feeling distressed by dealing with ‘overly demanding and unfair’ senior nurses and midwives (Bakibingi et al., 2012, p.8). Additionally, a cross-sectional descriptive study in Uganda aimed at examining factors that contributed to stress and burnout revealed difficulties with peer group as a source of extreme stress for the midwives (Mbatunde et al., 2020).

Furthermore, Fenwick and team's (2012) study in Australia aimed to explore newly qualified midwives' experiences and the factors that facilitated or constrained their development during the transition from student to registered midwife. The findings reported that the difficult collegial relationships seen in the culture of hospital midwifery practice prevented effective collegial relationship with midwifery colleagues. This difficult relationship also affected the new midwife's learning, confidence and competence. (Fenwick et al., 2012). The midwives reported feeling frustrated, this may have contributed to or worsened the adversity experienced.

Regarding the difficult collegial relationship, women in HICs have also confirmed the issue of lack of collegial support among midwives. For example, Pezaro et al. (2018) conducted a study in the UK on childbearing women's experiences of midwives' workplace distress, they explored midwives' psychological well-being from the perspective of ten new mothers. Although the sample was small, the study had important findings. The researchers found that midwives' stress levels were noticeable to the women, indeed three women had seen their midwife cry or become emotional. Most of the women reported that midwives turned to them for support, perhaps due to a lack of support from managers or colleagues. This lack of support from colleagues may have been a source of stress to the midwives and may have worsened the adversity experienced.

Munabi-Babigumira and colleagues (2018) review found that “disrespectful communication, lack of trust, poor teamwork and co-ordination, and an inadequate opportunity to discuss clinical practice could lead to poor interprofessional relations” (Munabi-Babigumira et al., 2018, p.29). They further reported that health workers created difficulties and chaos among themselves when they failed to recognise each other's strengths or “when they acted in a way that reinforced clinical hierarchies” (Munabi-Babigumira et al., 2018, p.29). The recent Cramer and Hunter (2019) literature review of research examined the association between midwives' emotional well-being and working conditions found a correlation between burnout with low support from senior colleagues, peers and medical colleagues. They also reported an association between burnout and stress from conflict and inadequate support from old colleagues (Cramer and Hunter, 2019).

3.4.1.3. *Attending to a traumatic birth*

Attending to a traumatic birth or dealing with a perinatal or maternal death has been a well-documented source of workplace adversity for midwives in both HICs and in LMICs (Beck and Gable, 2012; Rice and Warland, 2013; Sheen et al., 2014; Sheen et al., 2015; Sheen et al., 2016; Creedy and Gamble, 2016; Pezaro et al. 2016; Dartey et al., 2017; Dartey et al., 2019; Mweteise et al., 2020). There has been a recent acknowledgment that psychological trauma can occur to other people who are present at a birth. A woman's partner, midwives, student midwives and other health professionals present at a birth may experience a psychological reaction to a traumatic birth (Weston, 2011; Rice and Warland, 2013; Beck et al., 2015; Davies and Coldridge, 2015; Alghamdi and Jarrett, 2016; Greenfield et al., 2016; Schröder et al., 2016).

The term 'traumatic birth' is used in midwifery literature in a variety of ways. It is an emerging area of research with a paucity of literature, so defining the characteristics of experiencing a traumatic birth in someone other than the mother is currently difficult. However, Greenfield et al's (2016) systematic review, aimed at conceptualising the term, concludes that "a traumatic birth can be described as: the emergence of a baby from its mother in a way that involves events or care that cause deep distress or psychological disturbance, which may or may not involve physical injury, but resulting in psychological distress of an enduring nature" (Greenfield et al., 2016, p.257). It simply means a psychological response to events or care following a physical injury or death of mother or baby or both and also near misses in maternity by the carers. Rice and Warland (2013) suggested that the midwives' empathetic relationship with the woman may predispose her to the risk of emotional stress after witnessing or caring for a woman who has been exposed to a traumatic birth.

Beck (2004) also defined a traumatic birth as a clinical event that resulted in actual or threatened serious injury, a near miss or death of the mother or her child. Midwives may indirectly be at risk either by attending to a traumatic birth or listening to accounts of distressing childbirth experience from mothers, or both (Sheen et al., 2015). Studies have reported that more than two-thirds of midwives in Australia and over 95% of midwives in the UK had been exposed to a traumatic event at work related to managing traumatic births (Sheen et al., 2015; Spiby and Slade, 2015; Leinweber et al., 2017). Midwives who are frequently exposed to such work-related stressors may develop mental ill-health such as anxiety disorders (Muliira et al., 2015) compassion fatigue, secondary traumatic stress and in some cases, post-traumatic stress disorder (Leinweber and Rowe, 2010; Rice and Warland, 2013; Beck et al., 2015; Sheen et al., 2015; Schroder et al., 2016; Leinweber et

al., 2017). Thus, resilience may be highly relevant for midwives when faced with workplace adversity on a regular basis. This will be discussed later in the chapter.

Several studies have investigated midwives' experiences of attending a traumatic birth. For example, Sheen et al. (2015) used a postal survey, this was developed through the collaboration of a group of experienced midwives in the UK. It investigated midwives' responses following a traumatic birth experience. A total of 421 midwives participated, all of whom had a history of attending a traumatic birth. The findings revealed that 33% of the participants showed clinical symptoms of post-traumatic stress disorder (PTSD). Results also showed that midwives who had previous traumatic experience were likely to have more severe post-traumatic stress responses. The severity of symptoms of PTSD were measured using the revised impact event scale tool. These findings suggested that attending a traumatic clinical event may affect the midwife's emotional well-being. The results also suggested something more significant, it actually resulted in mental ill health i.e. PTSD symptoms. This was cumulative, which is to say, the more traumatic the birth experienced, the more severe the PTSD. One of the limitations of the findings was that the study was conducted using a postal survey where questionnaires often used are brief, simple, and easy to enhance a good response (Sepp, 2011). This may lead to poor quality data. Additionally, a response rate of 16% was reported, and the sample included midwives working within similar work settings (NHS) hence, application of findings to other settings should be treated with caution. It was also observed that the study did not make any recommendations with regard to effective ways of preparing and supporting midwives following traumatic perinatal events. Despite this limitation, the study is useful and adds to the body of literature on midwives' experiences following a traumatic clinical event as a source of stress which may have been severe and may have affected the midwives' mental health.

Another study in Ghana by Dartey et al. (2020) utilised a qualitative descriptive approach, it explored the physical effects of maternal deaths on their caregivers in the Ashanti Region of Ghana. Data were collected using semi-structured interviews and focus group discussions, with a purposive sample of 18 ward supervisors and 39 ward midwives. The findings indicated that grief over their patients' deaths led to physical and mental ill-health, including depression, insomnia, appetite loss, tiredness, and even social isolation. The study recommended that all hospitals in Ghana utilise employee assistance programmes, a workplace intervention programme designed for such purposes. The study did not describe the coping strategies that midwives used in dealing with such experiences. Similar studies in other LMICs reported that attending to traumatic birth could be a source

of workplace adversity among midwives (Mbattude et al., 2020; Dartey et al., 2017; Dartey et al., 2019; Mweteise et al., 2020).

Understanding the factors that may impact on midwives in their workplace is useful for further development of a mechanism which might help reduce stress and promote wellbeing. Some hospitals indicated that workplace adversity was a major concern because individuals' attendance and participation might be diminished (Noblett, 2003). This is because absenteeism and staff turnover, caused by work-related stress, may result in human and economic cost to an organisation (Noblett, 2003). Human and financial costs resulting from job stress strongly suggest that it is pertinent for all staff and employers to create healthier and less stressful working environments to minimise this cost.

The high attrition rate in Nigeria (Adegoke, 2013) shows that some of the professional and educational strategies available do not prepare staff to deal with workplace adversity. Although available studies on stress in Nigeria provided evidence of the high demands placed on the profession, they have not revealed how some individuals cope with such demand while others experience physical, psychological and social stress and burnout (Anyebe et al., 2014; Ladan et al., 2014). Therefore, the current study builds on previous studies which have explored workplace adversity and resilience among midwives in a maternity unit.

3.5. Perceived effects of workplace adversity on midwives

Exposure to workplace adversity has a considerable impact on midwives, including stress and burnout, job satisfaction, quality of care issues leading to poor patient outcomes, poor recruitment and retention of health workers, all of which may worsen the challenges of meeting the targets of SDG 3 (Macdonald, 2011; WHO, 2016; Filby et al., 2017; Kuforoji, 2017; Geraghty, 2018; Bogren et al., 2020). One of the perceived effects of exposure to workplace adversity is stress, resulting in burnout syndrome. The WHO (2019) writes that burnout is included in the 11th Revision of the International Classification of Diseases (ICD-11) as an occupational phenomenon. It is not classified as a medical condition. WHO (2019) defines Burnout in ICD-11 as follows:

Burnout is a syndrome conceptualised as resulting from chronic workplace stress that has not been successfully managed. Three dimensions characterise it: feelings of energy depletion or exhaustion; increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and reduced professional efficacy. Burnout refers specifically to phenomena in the occupational context and should

not be applied to describe experiences in other areas of life.'
(WHO,2019, p1).

Burnout has been regarded as one of the reasons midwives leave midwifery, this may impact on achieving UN sustainable goal 3c of staff retention and may further worsen staff shortages. For example, researchers in Malawi (Thorsen et al., 2011) utilised a cross-sectional descriptive survey, a validated tool was used to determine occupational stress levels related to burnout among 101 maternity health staffs in a district referral hospital. The Maslach Burnout Inventory (MBI) was used to measure the various dimensions of burnout. The MBI comprises three component scales: emotional exhaustion (9 items), depersonalization (5 items) and personal achievement (8 items). Each scale measures its own unique dimension of burnout. The authors did not explain the sample composition, and this may limit the generalisability of the finding. The findings concluded that burnout due to continuous exposure to occupational stress was higher among maternity staff than colleagues in other areas (Thorsen et al., 2011). This may be linked to the challenging maternity workplace setting irrespective of the region, and as such more studies may be required in midwifery.

In Uganda, exposure to workplace stress was associated with poor job satisfaction among a population of nurses (Nabirye et al., 2011). As well as poor job satisfaction, workplace adversity has been identified as affecting staff's personal lives. Demerouti et al., (2014) writes that a poor work-life balance causes a physical and emotional impact on an individual. Consequently, some studies have argued that such poor work-life balance has been linked to poor staff health and well-being as well as their retention in the workplace (WHO, 2016; Filby et al, 2017; Kuforiji, 2017). Additionally, physical challenges resulting from exposure to workplace adversity has also been identified among nurses and a wide range of other healthcare professionals in Nigeria. For example, the findings of researchers in Northwest Nigeria, as described earlier in the chapter, Ladan et al. (2014) and Anyebe et al. (2014), showed the physical and psychological impact of workplace stressors, these included: headaches, body pains, anger, frustration, low motivation and irritability. Workplace adversity was also linked to poor patient safety and quality of care among healthcare workers (Berland et al., 2008; Macdonald, 2011; Hunter and Warren, 2014; Kuforiji, 2017).

Regarding the issues of lack of resources and poor work environment, these have been considered as the push factors responsible for the exodus of staff to other HICs as described in the previous chapter. They may also affect the retention of staff in the workplace, thereby causing a further reduction in the staff-patient ratio. Also, Bradley et al. (2009, p.9.) declared that a health-related resource constraint worsens the issue of

workloads by causing 'time-consuming struggles to improvise', these may negatively affect maternal outcomes. Bradley et al. (2016) further identified poor work environments and resources as part of the health system structural drivers, resulting in disrespect and abuse of mothers. A lack of resources while providing care may lead to poor quality of care, resulting in maternal death and further increasing the country's unacceptably high maternal mortality.

From the above paragraphs, it could be concluded that workplace adversity is a global problem within healthcare systems leading to stress and burnout, and it is not limited to one specific region. The magnitude of the problem varies significantly between regions and depends on the structure of the health care system (Wright et al., 2017). While there was a range of evidence describing workplace adversity resulting to stress among nursing in HIC, further research is still required within maternity services in LMICs. The review shows that there is a need to explore various mechanisms used in navigating through workplace adversity among midwives working in maternity care settings.

The literature described workplace adversity as a range of negative elements affecting health care workers. Although throughout the literature review workplace adversity was conflated as stress, stress is a response to exposure to workplace adversity which may result in burnout. Some of the studies in LMICs referred to workplace adversity as stress and sometimes used the terms interchangeability (Bakibinga et al., 2012; Anyebe et al., 2014; Ladan et al., 2014).

The common sources of workplace adversity identified by midwives includes staff shortages with a resultant excessive workload, poor collegial relationship, lack of resources, and attending to a traumatic birth, amongst others. Most of the studies reviewed on workplace adversity have been undertaken in HICs (MacDonald, 2011; Hunter and Warren, 2014; Jackson et al., 2018) and have mainly focused on nurses rather than midwives. These studies have identified the difficult working conditions common in the healthcare setting and that health workers, including midwives, need to deal with challenging working conditions. The studies varied in their quality and credibility. Some of the quantitative studies had poor response rates, small sample sizes, were conducted in one geographical location, and also used a single instrument questionnaire for data collection (Thorsen et al., 2011; Lasebikan and Oyetunde, 2012; Anyebe et al., 2014; Ladan et al., 2014). This may limit the generalisation of the research findings to other populations. A strength of some of the quantitative studies was the use of tools such as OSAQ, MBI and general health questionnaire GHI questionnaire, they are validated instruments and may have improved validity and reliability of data collection. However, some of the findings were unclear in some of the studies, and several studies did not

provide clear recommendations on how the identified problem may be resolved. Also, there was a paucity of literature using a qualitative design to explore the causes of workplace adversity (Bakibinga et al., 2012; Dartey et al., 2017; Dartey et al., 2019; Dartey et al., 2020). Most of the studies used thematic analysis to analyse the data. The methods were not clearly explained and the steps in the analysis were not clearly defined. This may be due to the fact that in some LMICs, qualitative research knowledge is still evolving and may have influenced the quality of research studies conducted in the region. Nevertheless, these studies have contributed to understanding the impact of workplace adversity on health workers.

As a result of the above-mentioned issues more qualitative studies, exploring midwives' experiences in their workplace and the impact on the health and well-being of midwives in relation to workplace adversity and resilience, are needed to gain a greater understanding of the issues. Consequently, for the current study, a qualitative methodology was chosen and believed to be more appropriate. The concept of resilience and the various resilient strategies that health workers, including midwives, use to navigate workplace adversity is described in the following paragraphs.

3.6. Concept of Resilience

Undoubtedly demonstrating resilience occurs only as a response to adversity. Jackson et al. (2007) suggested that there must be an experience of adversity for one to develop resilience. Rutter (1999, p.119) broadly defines resilience as 'the phenomenon of overcoming stress or adversity'. The word resilience originates from the Latin 'resilire' meaning to jump back. It holds meaning for many situations, whether they involve individuals or groups (Edward et al., 2009; Kumpfer, 1999). Historically, the term resilient was used to qualify the 'degree of elasticity or adaptability' of any substance or an organ (Harriman, 1958; Chapman, 1992). Resilience is a term that has burgeoned in current literature explaining how individuals or a given population respond positively to a traumatic or significant life event (Lindstrom, 2001). It has also been described as a protective mechanism in children who have experienced a major life event, hardship and stress (Haggerty et al., 1996) or personal resilience of individuals exposed to extreme adversity, for instance, those exposed to tragedy (Kent et al., 2011) violence (Dutton and Greene, 2010) or terrorism (Soffer-Dudek et al., 2011).

Over the years, the construct of resilience and its significance for healthcare professionals has attracted attention globally (Jacelon, 1997; Hodges et al., 2005; McAllister and McKinnon, 2009). Although research in occupational settings is still ongoing, some studies have been conducted to examine the nature of resilience in caring professionals (Jackson,

2007; Kinmen and Grant, 2011; Macdonald, 2011; Adamson et al., 2012; Hunter and Warren, 2014). The concept of resilience helps us to understand why and how an individual responds more positively to a significant life event than another person, given the same circumstances. There are a range of understandings and definitions of resilience. These are described later in the section.

Hunter and Warren, (2014) pointed out that resilience has been conceptualised as an aggregate of traits or certain characteristics such as optimism, self-efficacy, and hardiness, which help an individual adapt to adversity. It is now widely accepted that resilience is a dynamic process developed over time and is rooted in internal and external factors (Tugade and Frederickson, 2004; Ungar, 2012). Neenan (2009) further argued that resilience is made up of adaptable cognitive, behavioural and emotional responses to adversity and can be learnt. Neenan (2009) also noted that what has been learnt may act as a mechanism in preparation for further adversity. Therefore, as a learned process, resilience is a resource available to all (Neenan, 2009).

Various definitions of resilience have been explored in a recent systematic review. Aburn et al. (2015) in New Zealand utilised a systematic method to examine how resilience is empirically defined. The design was an integrative review of empirical literature between 2000 -2015. The initial search showed that a large amount of literature (over 2,000 studies) had been published in various disciplines ranging from nursing, health, psychology, police, education, military and armed forces. The search revealed that the literature around nursing and health professionals drew heavily on work completed in other disciplines, largely psychology. As a result, the final search was not restricted to a particular profession, population or fields. About one hundred items were included in the final data analysis. The most striking finding of the review was that there was no universal definition of resilience. However, five key themes were identified underpinning the definition of resilience: 'Rising above to overcome adversity' i.e ability to deal with difficult situations; 'adaptation and adjustment', that is the ability to adjust in a difficult situation; 'ordinary magic': having an inner personal strength; 'good mental health': having positive psychological health, and 'ability to bounce back': the ability to recover from a difficult experience (Aburn et al., 2015. p.25). This reflects various definitions mentioned earlier in this discourse.

Building resilience has been regarded as a solution to stress associated with unpredictable workplaces (Foureur et al., 2013). Luthar et al. (2000) described "resilience as a dynamic process which encompasses positive adaption within the context of significant adversity" (Luthar et al., 2000, p.1). This definition may mean that individuals must first experience a major life event, the ability to remain positive throughout the

phenomenon defines them as resilient. In other words, resilience is an individual's ability to respond continuously to adversity in a sustained manner using appropriate coping strategies (Hart et al., 2007; Neenan, 2009; Hunter and Warren, 2014). Despite the various terms describing professional resilience, the key feature is the ability to overcome challenging situations using different resilient strategies, including optimism, reflections, self-awareness, self-efficacy, being assertive and collegial support, amongst others (Jackson et al., 2007; Macdonald, 2010; Adamson et al., 2012; Hart et al., 2014).

Various studies and theorising on the construct of resilience have been developed, focusing on four waves (Wright et al., 2013). In the first wave the studies focused on individual characteristics, including coping strategies, adaptation and self-efficacy. In contrast studies around the second wave focused on individuals' protective mechanisms. In the third wave, studies focused on interventions geared towards changing developmental pathways to enhance individual protective factors. Currently, studies around the fourth wave showed that the construct of resilience has been conceptualised from an ecological perspective (Masten, 2007; Ungar, 2008, 2011; Hart et al., 2014). These studies claimed that resilience might be present within an individual and also within the individual's physical and social environment. Resilience could thus be further influenced by the various interactions between individuals and factors within his/her environment (Koen et al., 2011b.c; Macdonald et al., 2016; Marie et al., 2016). The various experiences of resilience in the field of nursing and midwifery are explored below.

3.6.1. Resilience in Nursing

Resilience has been described as a useful attribute in other health care workers, including nursing. Fink, (2013) defines professional resilience as "A health and human service professional's commitment to achieving balance amid occupational stressors and life challenges, while fostering professional values and career sustainability". This is accomplished through a defined set of building blocks and individualised strategies' (p. 330). Professional resilience is, therefore, one of the necessary survival attributes of practising nurses and midwives. Jackson et al. (2007) describes resilience in nursing as maintaining a state of equilibrium and a sense of control in the face of adversity. Some studies have highlighted that resilience can protect against the development of emotional exhaustion and poor mental health in nursing (Davydov et al., 2010). Furthermore, some nursing resilience studies have investigated various strategies to deal with workplace stressors. For example, teaching nurses effective coping mechanisms and including practising stress reduction through mindfulness and self-care, these have been found useful in promoting resilience (Tugade and Fredrickson, 2004; Larrabee et al., 2010;

McDonald, 2011; Foureur et al., 2013; Macdonald et al., 2016). However, Ungar (2011) indicated a need to explore some of these strategies within a particular cultural context to better understand how some individual traits influence resilience building.

In Australia, Jackson et al (2007) conducted a systematic review, they investigated the key features of personal resilience in nursing, these included having a positive outlook, good interpersonal relationships, emotional intelligence, and spirituality. Other studies have investigated the way in which nurses developed resilience in the face of workplace adversity. For example, an earlier study on resilience by Judkins and Rind (2005) in Texas USA used a descriptive design to examine the relationship between resilience, job satisfaction and stress among home-based nurses (n=94). Findings showed that nurses' resilience had a positive association with job satisfaction and a positive correlation with lower levels of burnout experienced. However, this study was small in sample, so generalisability was limited. Despite the small sample size used in this study, the findings contributed to the empirical evidence that having a positive attitude to work significantly contributes to resilience.

In Australia, Cameron and Brownie (2010) used a phenomenological approach to explore the experience of the resilience of nine female aged-care nurses working in a residential aged-care facility. The study found that having a sense of purpose, requisite clinical knowledge and skills, self-reflection, work-life balance, and teamwork are important determinants of resilience in aged-care nurses. Although the study's sample size was small and conducted in a single location and facility, the findings contributed to the literature around the resilience of nurses caring for the aged in a HIC.

Similarly, in the USA, Mealer et al. (2012) conducted a qualitative study of 27 nurses working in an intensive care unit using semi-structured telephone interviews. The highly resilient midwives among the participants were identified through purposive sampling, this was based on the Connor–Davidson Resilience Scale. The Connor-Davidson resilience scale (CD-RISC) is made up of 25 items (see Appendix B), each rated on a 5-point range of responses on a scale of (0-4) as follows: not true at all (0), rarely true (1), sometimes true (2), often true (3), and true nearly all of the time (4). The scale is rated based on how the person has felt over the past month. The total score ranged from 0–100, with higher scores reflecting greater resilience (Connor and Davidson, 2003). Results from the Mealer et al. (2012) study found that optimism, spirituality, social networks, and having a resilient role model was useful for coping with stress among the highly resilient nurses. The authors compared those that scored highly with those that had low scores. However, non-resilient nurses did not possess the attributes found among the highly resilient nurses. In conclusion, the study recommended drawing on such attributes to promote resilience.

One of the strengths of this study was that it used a semi-structured interview, this may have enhanced the rich data collected and thus added to the literature around nurses' resilience.

Furthermore, Zander et al. (2013) used a case study methodology to explore the concept of resilience and factors used in developing resilience among five paediatric oncology nurses in Australia. Findings revealed that the nurses drew from effective collegial support, self-awareness, and self-reflection to develop resilience against workplace stress (Zander et al., 2013). One of the limitations of this study was the small sample size. Additionally, the study was conducted in a single location which may have reduced the variation in response. Despite the small sample size for this study, the findings contributed to the empirical knowledge related to the factors that are essential for workplace resilience.

In Canada, Jackson et al (2018) developed a grounded theory of burnout and resilience among nurses. This study was conducted to explore burnout and resilience in response to workplace adversity among critical care nurses. The study was guided by Straussian grounded theory, it explored the eleven participants' opinions regarding burnout and resilience in an urban teaching hospital in Canada. The study's findings revealed that burnout and resilience were indicators in responding to various forms of workplace adversity, which negatively impact upon nurses. The findings revealed a variety of techniques for resilience through the developed theory: managing exposure by using a variety of techniques: protecting, processing, decontaminating, and distancing. The study concluded that some of the organisational policies could impact upon this process and that nurse leaders can provide support throughout the process to reduce workplace adversity and enhance nurses' resilience (Jackson et al, 2018). One of the limitations of this study is that the authors did not provide details on the method used to select resilient midwives before the theory generation. Despite this, the findings contributed to the knowledge about the processes needed for developing resilience among nurses.

In Palestine one qualitative study adopted the social-ecological fourth wave approach in investigating resilience among community mental health nurses. These researchers (Marie et al., 2016) used a qualitative interpretive design to explore fifteen community mental health nurses' resilience using interviews, observations, and document analysis of written job-related policies. One of the major themes described as a source of resilience among the participants was "Sumud and Islamic Culture". Sumud is an Islamic concept for remaining steadfast and it includes the importance of religion and faith for coping among community mental health nurses (Marie et al., 2016). Other findings, such as using the supportive network and personal resources, were similar to resilience resources, as

identified by previous studies. However, the study was conducted among community mental health nurses working in a conflict zone. Perhaps the level of adversity and resilience may differ from those of nurses in other hospital settings. As a result, the transferability of findings should be treated with caution. Despite this, the study provided an understanding of resilience from a particular cultural context and from a socio-ecological perspective where religion and culture served as an important catalyst for the development of resilience.

In LMICs, studies regarding the resilience of professional nurses in public and private healthcare facilities were conducted in South Africa. Researchers (Koen et al., 2011a) used a cross-sectional descriptive design to examine the prevalence of resilience in a group of professional nurses $n = 312$ and to determine the differences in the level of resilience among the nurses in private versus public contexts. Using convenience sampling Koen et al., (2011a) used five validated tools to assess the prevalence of resilience among the respondents. The findings reported that 30 participants (10%) were less resilient, 149 participants (47%) were moderately resilient, and 133 participants (43%) seemed to be highly resilient. The nurses in private health care had significantly higher levels of resilience than nurses in public health care. The relatively small number of participants ($N = 312$) was the result of a delay in obtaining approval to conduct the study in two public hospitals, this meant that those hospitals could not be included in the study. Due to the convenient nature of this sample generalisability should be treated with caution. The findings of the study may only be generalised in a similar context; however, despite this limitation, the findings provided information on the level of resilience among this group of nurses in an LMICs setting with more resilient nurses. The study recommended a qualitative study of the resilience of this group of nurses.

In addition to their quantitative study, Koen et al. (2011b) published the qualitative component of their study with nurses in public and private health facilities. This qualitative phase of the study explored the experiences of 35 nurses identified as resilient and ten nurses considered less resilient from their previous quantitative survey (Koen et al., 2011a). Findings revealed that the resilient nurses drew from personal resources and supportive relationships within a religious, cultural context for enhancing their resilience ecologies (Koen et al., 2011b). The findings correspond with the concepts identified in the literature as useful for developing resilience. However, the study did not provide a clear explanation of which qualitative tool was used for data collection, also it did not describe how trustworthiness was achieved so as to judge the credibility of the study. Despite this limitation the study provided a means of understanding resilience from a particular socio-cultural context. The findings can be linked with the social-ecological wave of resilience.

Furthermore, the researchers (Koen et al., 2011c) developed a guideline for resilience based on their previous studies' findings (Koen et al., 2011a, Koen et al., 2011b). The guideline focused on the importance of 'the external environment with protective factors, including the nursing profession's uniqueness and social support systems, enhancing nurses' working conditions; individual characteristics including spirituality and other resilience processes' (Koen et al., 2011c). Overall, the guideline considered the social and behavioural nursing environment and psychosocial perspectives. Therefore, it can be suggested that some of these findings may be consistent with the social-ecological wave of resilience.

A more recent resilient qualitative study by Benade et al. (2017) was conducted to explore and describe the coping strategies of the nurses caring for older people in South Africa. The study was conducted in three phases. In the initial phase, the demographic variables of the participants (n=43) were gathered, and narratives were documented. In the second phase, four focus group discussions were conducted with seventeen participants and finally, guidelines for resilience were formulated in the third phase. The findings revealed the importance of nurses' resilience to deal with the emotional nature of the work, staff shortages, physical demands of the work and the dependency of older people. These included some personal, professional, contextual, and spiritual strengths used to handle workplace adversity. In conclusion, the participants' identified strengths were used to formulate recommendations to strengthen nurses' resilience for older people (Benade et al., 2017). This study built on Koen' et al. (2011a, b,c), studies in South Africa to describe and recommend the resilient strategies among nurses caring for the elderly. This study provided an insight into resilience among nurses in LMICs.

Furthermore, most of the reviewed studies concluded that in order to develop resilience; nurses needed to have access to resources that included identifying key resilient strategies and support provided at the organisational level (Gillespie et al., 2009; Macdonald, 2010; Zander et al., 2013; Macdonald et al., 2016). Consequently, McAllister and McKinnon (2009) put forward that learning and drawing from resilient strategies are critical components of health and well-being programmes for healthcare professionals. Therefore, understanding the way in which nurses deal with stressful situations through resilience is essential so as to overcome workplace pressure (Judkins and Rind, 2005; Jackson et al., 2007; Macdonald et al., 2016).

In the next section, resilience and resilient strategies in midwifery are discussed, noting that these may differ from the nurses as midwives have more autonomy and more responsibility than nurses.

3.6.2. Resilience in Midwifery

Most studies on resilience have predominately focused on nursing and other health professionals, rather than midwives working specifically in maternity care services, especially in LMICs, where midwives are mostly double qualified. Resilience in midwifery is pertinent because their work entails dealing with emotions and the high rate of mortality and morbidity in LMICs (Leinweber and Rowe, 2010; Pezaro et al., 2016; NDHS, 2018.). Resilience in midwifery is concerned with midwives' ability to respond positively to the adversity they encounter in their work environment (Hunter and Warren, 2014). Hunter and Warren (2014) described this as professional resilience. They further argued that professional resilience enables the midwife to remain positive and motivated in midwifery practice. Only a few studies in midwifery have explored resilience and the resilient strategies used in the face of workplace adversity. The following studies explore some of the resilience strategies identified:

In Australia, McDonald et al (2011) used a case study approach, interviews and focus group discussion to explore workplace adversity and resilience amongst fourteen nurses and midwives working in a maternity unit. The study was a work-based intervention conducted in different phases. The initial findings, conducted prior to the intervention, revealed that participants thrived in the face of adversity and that this was connected to the effective collegial network and personal traits, these included optimism and self-care. This support network enhanced the ability to cope with organisational hierarchy problems, created a sense of belonging and reduced their emotional burden, resulting in an increase in morale at work and their job satisfaction (McDonald et al., 2011). The authors revealed that the intervention was positively received by participants who felt it benefitted them both personally and professionally. Some of the professional benefits included: better group dynamic; positive, supportive communication; and increased assertiveness and confidence within the hospital setting.

The intervention improved supportive professional relationships amongst the participants and improved resilience through self-reflection, self-care, and improved communication skills. However, it is difficult to determine the findings' credibility as some key facts were not mentioned. Firstly, the researchers did not clearly state the number of midwives included and did not differentiate between nurses and midwives in the findings. Secondly, it is not clear who delivered the intervention nor who collected the evaluated data. The study was conducted in a single location, which could have prevented other nurses and midwives' participation, thus hindering the sharing of experiences. Despite these limitations, the study is useful in providing insight into the ways in which resilience could

be improved within midwifery. The findings also supported earlier studies that mentioned the significance of effective teamwork and the hospital management's role in developing resilience.

Three years later, Hunter and Warren (2014) conducted an explorative qualitative descriptive study, this included eighteen midwives who self-identified as resilient in an online study. It was the first resilience study conducted specifically amongst midwives in the United Kingdom. The study identified challenges to resilience, these included staff shortages, extensive paperwork and unsupportive organisational culture. However, Hunter and Warren (2014) suggested that the use of some proactive and pragmatic common resilient strategies, including self-awareness and collegial support, had helped build resilience among midwives. Hunter and Warren's study provided insight into several aspects of midwifery resilience, in particular facilitators and barriers to resilience. The facilitators to resilience were personal factors, these included gaining perspective, mood changes, social supports, work-life balance, and self-efficacy. The study's findings also noted that love for midwifery practice, sense of public service, the need to self-care, avoidance of stressors and supporting and empowering inexperienced colleagues were professional factors that facilitated resilience. On the other hand, the barriers to professional resilience noted were professional challenges, workplace conditions and the inability to provide the desired quality of care. The participants also noted a perceived bullying culture and constrained professional practice at the micro and macro levels as barriers to professional resilience. Hospital policies and protocols restricted individuals at the micro-level, while hospital politics and the bureaucratic management styles prevalent in clinical practice hindered flexible working conditions and undermined occupational autonomy (Hunter and Warren, 2014). However, the study has some limitations as the study was conducted online, this is perceived as a weakness. The inability to observe body language, gestures and instantly probe responses for more depth and clarity in the online study may reduce the quality of the data gathered. Secondly, the midwives had similar years of experience and were self-selected, this may have reduced the response variation. Despite these limitations, the study provided a valuable insight into the ways in which resilience can be promoted among midwives, specifically working within the maternity setting.

In a more recent qualitative study, Sabzevari and Rad (2019) explored resilience strategies against working pressures among twelve midwives in Iran. Participants with between one and twenty years of work experience were purposefully selected. Midwives who had experienced severe stressful conditions were selected using snowball sampling and semi-structured face-to-face interviews as the data collection tool. The data were

transcribed and analysed using content analysis, this revealed some of the resilient strategies used against workplace stress. These included reading and reciting some religious verses for strength; having a network of support from colleagues and family; using various decision-making skills and sharing in mothers' joy (Sabzevari and Rad, 2019). The study recommended that hospital managers could provide midwives with a supportive role to minimise the risk of developing burnout. However, the study did not describe the kind of adversity experienced by these midwives. It did not provide the exact number of midwives who experienced the stressful conditions mentioned by the researchers. Nevertheless, the findings provided some insight into resilient strategies such as the midwives' religious practices, thereby adding to midwifery's body of knowledge.

Overall, the literature review revealed that few studies had been undertaken to explore the resilience of midwives, justifying the need for the current study. Most of these studies focused on the resilience of nurses (Jackson et al., 2007; Cameron and Brownie, 2010; Macdonald et al., 2011; Mealer et al., 2012; Zander et al., 2013) and midwives in HIC (Macdonald et al., 2016; Hunter and Warren, 2014). When looking at the context of LMICs, there is a paucity of literature that described how resilience is experienced among midwives in maternity settings in LMICs. Throughout the literature review, the available literature in LMICs explored resilience among nurses in two African countries South Africa and in Sierre-Leone (Koen et al., 2011a, b,c; Vesel et al., 2015; Bernade et al., 2017). This was done in a bid to explore how resilience can be developed and fostered among this population. Some of these studies used quantitative and qualitative methods to examine and explore both nurses and midwives' resilience. Although some of the study sample sizes were small (Zander et, 2013; Sabzevari and Rad, 2019).

Regarding the qualitative studies, some studies did not describe how trustworthiness was ensured in order to judge the credibility of the findings (Koen et al., 2011; Benade et al., 2017). Also, as qualitative studies generalisability is not appropriate, but these studies all contribute to the body of evidence and provide useful insight about resilience in midwifery and also into the way resilience was experienced by healthcare workers.

3.7. Summary of literature review

Resilience has been identified as a positive response to adversity, with indications that this can be developed. Most of the studies exploring workplace adversity and resilience among midwives were conducted in HIC. The review of the literature identified a gap in knowledge regarding the experience of workplace adversity and resilience of midwives in LMICs, such as Nigeria, and that justifies the need for the current research. Thus, to gain

deeper insight into midwives' experiences of workplace adversity and resilience in a low resource setting, research is required. A grounded theory was thought to be a suitable approach to explore the concept of resilience in Nigeria among midwives working in maternity care settings. Thus, the current study aims to describe the characteristics of workplace adversity and resilience necessary to produce a theory of midwives' workplace adversity and resilience, this may then be useful and transferable to a setting with similar workplace issues and challenges. The following two chapters, Four and Five, present the methodology and methods utilised to collect and analyse the data.

CHAPTER FOUR - Methodology

4.1. Introduction

This chapter presents the methodology used in the study. It describes the research paradigm, research design, the grounded theory methodology, the various types of grounded theory and the differences between each type. The chapter also describes the constructivist grounded theory used for data collection and analysis in this study.

4.2. Research Paradigm

Generally, the research process was informed by three main dimensions: ontology, epistemology and methodology, which collectively informed the approach used to conduct the research (Creswell, 1998; Polit and Beck, 2006). Mason (2002) wrote that it is imperative that before conducting a research study, the researcher's epistemological and ontological position is clearly identified. This will help the researcher know how their positioning might guide their methodological decisions.

In this study, the research design was built on the assumptions made about the nature of reality (ontology) and how to gain knowledge about it (epistemology). Ontology is 'the nature of reality' (Lincoln and Guba, 1985, p.37), while epistemology refers to 'the nature of the relationship between the knower or would-be knower and what can be known' (Guba et al., 1998, p.201). The initial literature search and review informed my ontological and epistemological approach. This helped to achieve consistency between the research phases and the decision on research methodology, method of data collection and the analysis that was most appropriate for the study.

Creswell (2012) defined a research paradigm as a basic set of beliefs that guides action. Polit and Beck (2008) contend that a research paradigm is the world view or general philosophical orientation about the world. Creswell (2012) further noted that the world view arises from a discipline's orientation, students' and supervisors' inclination and previous research experiences. There are two broad paradigms in healthcare research: positivism and constructivism/ interpretivism paradigm (Polit and Beck, 2019).

Both paradigms investigate the world, but the positivist paradigm assumes a world that can be observed and measured. Polit and Beck (2017) noted that the basic principle of positivism is a reality out there that can be observed and measured. On the other hand, the constructivist paradigm is of the premise that reality is not fixed but rather a construction of the individual participating in the research. A constructivist paradigm

assumes 'that reality cannot be objectively discovered, but instead people, including researchers, construct the realities in which they participate' (Bryant and Charmaz, 2007a p. 607). Polit and Beck (2017) assert that the participants' experiences are crucial to understanding the phenomenon under study. Hence, personal interaction is seen as the primary approach to explore them. In constructivist paradigm 'reality is socially constructed' (Mertens, 2005 p.16) this means that reality has multiple meanings and value which are subjective and experiential. They are also created and not discovered. Qualitative research fits into this tradition based on the assumption that to make meaning of the world, human behaviour should be understood through interactions with people. The philosophical underpinning for this study is that of the constructivist paradigm, as explained further.

The study aimed to explore the experiences of workplace adversity and resilience among midwives. A quantitative descriptive survey would be inappropriate to explore the participants' experiences regarding the phenomenon. Arguably, quantitative research could investigate individual experiences through a questionnaire, but this would not give in-depth information or data. A qualitative approach is most appropriate when little is known about a topic; hence exploration is needed. Therefore, utilising a methodology underpinned by the constructivist paradigm, which seeks to explore human experiences in their natural environment, was thought to be more appropriate to meet the research's aim of better understanding the phenomenon under study. Thus, grounded theory firmly rooted in the constructivist paradigm was used to explore the midwives' experiences of workplace adversity and resilience. Grounded theory was considered to be suitable for this study because little had been documented on the concept of workplace adversity, how it is experienced, the construct of resilience and resilient strategies, especially among midwives in Northern Nigeria and other LMICs. A previous study by Hunter and Warren (2014) in the United Kingdom, utilised an exploratory, descriptive design to describe midwives' understanding and experience of professional resilience. This research seeks to build on that study by deepening the analysis and enabling theory generation. It will also build upon existing research on maternal health regarding workplace stress and resilience from Nigeria and other LMICs. The current research aims to explore resilience in a different setting with differing levels and types of adversity and professional resilience. Grounded theory is thus suitable for this study which seeks to generate a theory specific to midwives in the Nigerian midwifery context, but which can also be transferable to other settings. Data was collected and analysed using an inductive, and abductive research process to generate theory on the ways in which midwives experience workplace

adversity and the various strategies they use to deal with workplace pressure. The theoretical framework used for this study is described in the next paragraph.

4.3. Theoretical Framework

4.3.1. Social constructionist theory

Social constructionism is a discussion of the acquisition of knowledge through the deliberate activity of individuals or groups (Thomas et al., 2014). Social constructionism offers one way to understand the nature of reality (Andrew, 2012). It is believed that multiple realities and previous experiences, and individual belief systems may influence individual perception (Guba and Lincoln, 1989). Constructionism is concerned with how we develop meaning from what we know, based on individual learning within a particular social context (Young and Collin, 2004; Thomas et al., 2014). The work of Berger and Luckman (1991) has been noted to influence this theory's development. Social constructionism has been viewed by Berger and Luckman (1991) as concerned with the nature and construction of knowledge, origin of the knowledge and its significance to the society. They view knowledge as being created by the interactions of individuals within a society. Social construction is predominantly about the social construction of reality. In this study, the interaction between the researcher and the participants provides an avenue to understand how workplace adversity and resilience are experienced.

Social constructivists believe that individuals develop subjective meanings of their experience by directing it to particular objects or things. These meanings are usually in multiples giving the researcher a broad view of the experiences rather than narrowing meanings into a few categories (Cresswell, 2013). The goal of the research is to explore the participants' experiences of workplace adversity and resilience.

4.3.2. Influence of Symbolic Interactionism on Grounded theory

Symbolic interactionism is a sociological perspective that depends on the symbolic meaning people ascribe to social interaction processes. Symbolic interactionism addresses the subjective meaning which people place on objects, behaviours or events based on what they believe is true (Griffin, 1997; Clarke, 2005). Charmaz (2014) defines symbolic interactionism “as a dynamic theoretical perspective that views human actions as constructing self, situation and society” (Charmaz ,2014 p.262). Symbolic interactionism is a perspective that views human action and interaction and the construction and reconstruction of meaning within levels of context as very important, it

forms a crucial point for theory development (Charmaz, 2014). In this process, the action and interaction change the context and lead to new meaning and new action (Glaser, 2005).

Grounded theory is rooted in symbolic interactionism, a social psychological perspective developed by George Herbert Mead in the 1920s and 1930s (Holloway and Galvin, 2015) which has been viewed as the philosophical foundation of Glaser and Strauss's grounded theory approach (Hutchinson and Wilson 2001; Charmaz, 2011).

Furthermore, Mead (1930) believes that the use of symbols is an important part of human life. He noted that individuals develop their action in response to others; they take account of each other's behaviour and interpret and respond to it (Holloway and Galvin, 2015).

The meanings are further re-interpreted in the event of any change. Interactionists contribute to grounded theory by demonstrating that human beings are active agents in their own experiences, and they act according to their interpretation of those experiences (Holloway and Galvin, 2015). Human beings are creative individuals who 'plan, project, and revise' their thoughts and behaviour in relation to others within a particular context and their actions can only be understood in this context (Holloway and Galvin, 2015, p.34). Therefore, the grounded theory emphasises the importance of this context in which people function and share their social world to others (Holloway and Galvin, 2015).

The current study is based on the understanding that the midwives' experiences of workplace adversity and resilience are influenced by their social backgrounds and the context they live and work in, this affects their experiences to provide birth services to mothers and their babies. Mead's views informed the philosophy used in this study and also Charmaz (2014) arguments in her approach to the social construction of knowledge. The midwives' experiences of workplace adversity and resilience will be communicated through the generated theory.

4.3.3. The Social ecological model of resilience

As discussed in chapter three, the current fourth wave of resilience research and theorising has focused on a social ecological model. The social ecological perspective of understanding resilience proposes that contexts such as workplace settings, family environment as well as the community may contain important factors which interact to influence the person's overall development of resilience. Contexts will vary between individuals, and an individual's resilience may depend on the quality of their immediate environment, the strength of the family support system and factors within the community (Santos, 2012; Goodman, 2017).

Furthermore, as emphasised by Ungar (2008: p.225),

“In the context of exposure to significant adversity, whether psychological, environmental, or both, resilience is both the capacity of individuals to navigate their way to health-sustaining resources, including opportunities to experience feelings of well-being, and a condition of the individual's family, community, and culture to provide these health resources and experiences in culturally meaningful ways”.

This definition reflects that individual, families and their community all form an ecosystem, that interact to influence the optimal functioning and resilience of an individual. A social ecological perspective of resilience emphasises the socio-cultural impact of protective factors of resilience embedded in the family and social system within different contexts (Ungar, 2011). Thus, the focus shifts from resilience residing within an individual and being within an individual's control, to being embedded in wider systems. This understanding calls for a focus on how factors within the environment influence resilient individuals (Ungar, 2012)

In this regard, understanding midwives' resilience calls for studies which take account of social ecological perspectives by exploring the underlying social factors present within and outside the workplace, which could strengthen the midwives' coping abilities and resilience.

Understanding the social ecological theory of resilience may be useful in developing a grounded theory of midwives' workplace resilience and can also inform a deeper understanding of the social processes that contribute to resilience in a challenging workplace. It can also offer midwives and policymakers a broader perspective for designing and implementing effective interventions. For example, drawing on how resilience could be seen as a systems issue, existing not only at a micro-level (i.e., the individual midwife) but also as a construct of several intersecting factors at the meso level (i.e. hospital and regional level factors such as policy, management, resources and local cultures) and also with macro-level influences such as national policy and as well as resource decisions. The social ecological model has also been useful in conceptualising resilience in other studies in Palestine and United Kingdom. For example, Marie et al (2016) used social ecological model to understand the resilience of community mental health nurses in Palestine. In midwifery, no studies were found using the social ecological model to understand the resilience of midwives. Thus, this current study is deemed appropriate and would be useful to understand resilience from a social ecological perspective which is the current fourth wave of conceptualising resilience.

4.4. Research Design

The research focuses on exploring midwives' experiences of workplace adversity and resilience; thus, a qualitative design is more appropriate. A qualitative approach helps the researcher to better understand the construct under study through interaction between the researcher and the participant (Polit and Beck, 2008). The researcher can probe the participants' responses during the interaction in order to gain deeper insights. Esterberg (2002) suggested that the qualitative approach helps the researcher better understand the participants' experiences and allows flexibility to pursue both the researchers' ideas about the topic and to understand the meanings that emerge from the data. Qualitative studies create a deeper understanding of how the respondent experiences the phenomenon of workplace adversity in their natural environment via researcher-participant interaction (Bryman and Burgess, 2002).

4.5. Methodological Approach

Denzin and Lincoln (2011b, p. 91) defines methodology as “the best means for gaining knowledge about the world” and forms part of the researcher's belief system. It can also be considered as a guide to the research paradigm (Denzin and Lincoln, 2011b). Initially different forms of qualitative inquiry were considered but my attention was drawn to three main qualitative approaches that tend to address different types of questions. Firstly, phenomenology, derived primarily from philosophy and psychology, explores 'meaning', lived experiences, questions, and intends to interpret the meaning of an experience for participants (Denzin and Lincoln, 2005). Phenomenology focuses on the interpretation of individual experiences rather than looking for shared experiences and meanings.

In contrast ethnography, which is derived from anthropology, seeks to answer questions surrounding issues such as values, beliefs, and practices among a cultural group within a given geographical context (Denzin and Lincoln, 2005). From my reading and philosophical standpoint of constructionism, neither of these traditions addresses the central issue in the present study: to understand the processes during and following the midwives' experiences of workplace adversity, leading to the development of resilience. Although phenomenology could help explore the midwives' experiences it focuses on interpreting individual experiences rather than looking for shared experiences and meanings. However, interpretation of the midwives' experience is not the focus of this study. Also, bracketing of individual experiences is very crucial in phenomenology. This study will use the grounded theory research process to understand the participants' experiences and resilience and to further develop a theory explaining how midwives build

resilience in the face of adversity. My experience is important in enhancing theoretical sensitivity, although reflexivity was useful in setting aside this researcher's experience.

Grounded theory is well suited for this study since it primarily deals with 'process' and experiences over time. It also attempts to develop a theory grounded in data inductively and inform ways of generating action and process in a given context (Glaser, 1998). Thus, grounded theory was found suitable for this study.

4.5.1. The Grounded theory Approaches.

Grounded theory has its roots in sociology and was developed in 1965 by sociologists Glaser and Strauss (1967), who proposed a new kind of qualitative research called grounded theory: 'the discovery of theory from data systematically obtained and analysed' (Glaser and Strauss, 1967, p.1). Grounded theory helps the researcher describe and explain the key social, psychological, and structural processes in a social setting. Polit and Beck (2017) assert that most grounded theory studies focus on discovering a core variable that is central to describing a social event. Willig (2013, p.69) writes that "grounded theory seeks to generate a detailed explanation of phenomena that is grounded in reality". Grounded theory is the end-product of this process; it provides an explanatory framework to understand the phenomenon under study. Charmaz (2014) defined grounded theory as a systematic process for collecting and analysing qualitative data to generate theories that are grounded in the data. It is employed where little is known about a phenomenon (Holloway and Galvin, 2015).

4.5.2. Types of Grounded theory

Grounded theory has been described as having three known methodological approaches. These include the traditional grounded theory associated with Glaser; secondly, the evolved grounded theory associated with Strauss, Corbin and Clarke; and thirdly, the constructivist grounded theory associated with Charmaz (Bryant and Charmaz, 2007; Birks and Mills, 2015).

Birks and Mills (2015) suggested that each of the three known approaches is the extension and development of Glaser and Strauss's original grounded theory. Furthermore, Glaser (1978) acknowledged that the goal of the first grounded theory approach, the traditional or the classical grounded theory, is to generate a conceptual theory that accounts for a pattern of appropriate behaviour for the people involved. However, the second approach, the evolved grounded theory, was informed by symbolic interactionism and was borne out of Strauss, Corbin and Clarke's work. The third

approach, constructivist grounded theory, is guided by symbolic interactionism principles underpinned by constructivism and developed by Charmaz, a symbolic interactionist. (Birks and Mills, 2015).

The constructivist grounded theory methodological underpinnings focus on the way participants construct meaning about the phenomenon under study (Charmaz, 2006). In contrast to traditional grounded theory and the evolved grounded theorists, Charmaz took a constructivist stance with constructivist grounded theory, relativist ontology and subjective epistemology (Charmaz, 2006, 2009, 2014). Constructivist grounded theorists acknowledge that reality is a social construction between the researcher and the researched (Charmaz, 2006, 2014, 2017). It is worthy of note that the constructivist grounded theorists do not object to the existence of objectively real worlds, but they are more concerned with the “world made real in the minds and through the words and actions of its members” (Charmaz, 2000, p. 523). Constructivist grounded theory has a subjective epistemology due to its assumptions that researchers are not separate from the research and that knowledge is co-created (Charmaz, 2000, 2006, 2014).

There are general commonalities across all the approaches of grounded theory methodology as they have a common set of ‘family resemblances’ (Bryant and Charmaz, 2007b, p. 11) which stands as the key attributes of a grounded theory study as seen in Table 4.1. These include that all the variants of the grounded theory are geared towards explaining a social process. Usually, they begin with inductive reasoning, concurrent data collection and analysis, constant comparison and memo writing. They also use theoretical sampling for theory generation; finally, they focus on the generation of a grounded theory grounded in data generated from interaction with the research participants (Charmaz, 2006, 2014, 2017). However, some factors help separate the differences between these approaches, including the researcher's philosophical position, use of literature, and the coding technique (Charmaz, 2014).

Table 4. 1: Table showing the different approaches of Grounded theory methods and their differences, including the researcher's role.

Approach	Use of literature	Philosophical underpinnings	Role of the Researcher	Coding
Classical Glaserian Grounded Theory	Delayed	Positivist or Objectivist	Viewed as a blank state	Open, selective, Theoretical.

Straussian Grounded theory	Preliminary required	Pragmatist, Symbolic interactionism	Intermediate role	Open, axial, Selective coding
Constructivist Grounded theory	Preliminary required	Constructivism	Co-cocreator of Knowledge	Initial, Focused, Theoretical

4.5.3. The Constructivist Grounded theory and this study

Kathy Charmaz is a sociologist, she developed constructivist grounded theory based on her ideas from the earlier researchers of grounded theory: Barney Glaser and Anselm Strauss (Charmaz, 2006, 2014). Constructivist grounded theory modified grounded theory, by moving it from its earlier positivist philosophical standpoint to a constructivist perspective (Bryant and Charmaz, 2007; Charmaz, 2017). This began in 1995 when Charmaz wrote about her ideas during the 'crisis of representation' (Denzin and Lincoln, 2005, p. 18). It was the paradigm shift period when qualitative researchers were seeking new models of truth because objectivity had become problematic (Birks and Mills, 2011). However, Charmaz (2008) argues that the constructivist grounded theory "builds on Glaser's useful methodological strategies ... but it does not duplicate the logic of inquiry in classic grounded theory statements" (Charmaz, 2008, p.136).

In this study, a constructivist grounded theory methodology was used because it helped to explore and develop theories regarding social processes as guided by the principles of symbolic interactionism (Charmaz, 2006). Constructivist grounded theory is a constructive methodology that believes the creation of knowledge is the responsibility of the researcher and the participants rather than by the researcher developing preconceived ideas (Charmaz, 2006).

However, Rieger, (2018, p.9) contends that "through considering the study purpose, the philosophical implications of the different grounded theory approaches, and the specific, pragmatic concerns of a situated study, researchers can determine the best fit for their work". As mentioned earlier, bearing such contentions in mind and taking a constructivist stance influenced the choice of constructivist grounded theory in this study. Furthermore, Rieger (2018, p.9) suggested that the study's purpose is of 'utmost importance' in selecting a type of grounded theory approach. Rieger further provided an example that if the researcher's goal is to discover an 'explanatory theory and identify variables', the classical grounded theory may be more suitable (Rieger, 2018, p.9). However, suppose a

researcher desires a 'theoretical understanding of a situated process' or understanding a social process, then the constructivist grounded theory may be more appropriate to explore such knowledge (Rieger, 2018, p.9). This ensures that the study's expected theory is consistent with the 'methodological approach' selected (Rieger, 2018, p.9). The current research aimed to generate a theoretical understanding of midwives' workplace adversity and resilience; thus, a constructivist grounded theory was considered to be the best fit. Finally, constructivist grounded theory procedures are more clearly defined and maybe more user-friendly for a novice researcher from a pragmatic standpoint (Reiger, 2018). Charmaz encouraged the use of a preliminary literature review, as discussed earlier, this informed the decision to use constructivist grounded theory methods, amongst other reasons in the current study.

4.6. Summary

This chapter described the philosophical underpinning of the study, the design, and the methodological approach. It also described the various types of grounded theory, the constructivist ground theory approach and the reason for its application to this study. The next chapter presents the methods used.

CHAPTER FIVE - Methods

5.1. Introduction

The chapter explains how grounded theory and its essential steps were used to implement the study's design. Methods are the techniques or procedures that researchers use to answer their research questions. Consequently, choosing appropriate methods suitable for answering the research question, including the recruitment of participants, sampling of participants, data collection and analysis, and communicating the research results, is guided by the research methodology and the expected outcomes of the study (Crotty, 1998), and these will be discussed in this chapter. This chapter explains the way in which the constructivist grounded theory was used and its essential steps of data collection and analysis. It also provides an explanation of how ethical consideration, trustworthiness and reflexivity were achieved in this study.

5.2. Research methods

5.2.1. Research Aim

The study aims to explore the phenomenon of workplace adversity and the experience of resilience among midwives, and to develop a middle range theory on workplace adversity and resilience.

5.2.2. Research Objectives

1. To explore the characteristics and experiences of workplace adversity among midwives working in tertiary hospitals in Northern Nigeria.
2. To explore these midwives' understanding of the construct of resilience
3. To explore these midwives' views about the various resilience strategies they use for dealing with workplace stressors.
4. To develop a middle-range theory of midwives' workplace adversity and resilience.

5.2.3. Inclusion criteria

- Midwives who were working in the department of obstetrics and gynaecology unit of the two tertiary hospitals at the time of data collection.
- Midwives who were willing to participate in the study.

5.2.4. Utilising the constructivist grounded theory in this study

In this study, Charmaz's (2014) approach was used as a guide, this included her stance on the use of a literature review. Strauss and Corbin's (2008) coding framework was used to link the relationship between categories in order to generate grounded theory. The coding paradigm was resorted to after several attempts had been made to develop the theory. The coding paradigm was useful in linking the categories together due to the nature of the framework (see 5.9.6) and from a pragmatic standpoint. This has also been used by other grounded theorists to help with the visual display and understanding of the relationship between the categories and the generated theory. For example (Zhang, 2013) used the coding framework to support the development of the theory of professional construction among Chinese midwives.

The current study was conducted with the researcher at the centre of the data collection process, in constructivist grounded theory the researcher is the instrument for data collection. The importance of the researcher-participant relationship was considered as significant for theory generation. Intensive Interviewing was used as required in the data collection, probing further as new lines of inquiry opened. Field notes were used in the study to explain and support some of the participants stories, and also experiences during the period of data collection and analysis. Memos were used extensively during the data analysis and were crucial in generating the grounded theory. Reflexive memos were used to set aside personal and professional experiences and to ensure the quality of the generated theory. The generated grounded theory was based on an understanding of the findings from interaction with the participants.

5.2.5. Population and Setting

The study population were all clinical midwives working in the obstetrics and gynaecological units in two tertiary hospitals In Northern Nigeria, named hospital A and hospital B, to protect the anonymity of the two research sites. The two hospitals were chosen in order to increase the possibility of more participants necessary for theory generation.

Midwives working in tertiary hospitals were selected because other studies had indicated that midwives working in hospital settings were more likely to experience stress, compassion fatigue, post-traumatic stress disorder and burnout (Leinweber and Rowe, 2010). This is an example of the value of undertaking an initial literature review, as described in Chapter Three.

Hospital A is situated in the outskirts of a city. This hospital is one of Nigeria's first-generation teaching hospitals designed to serve as a principal tertiary health institution in the northwest geopolitical region. It has more than 2000 technical staff (physicians, nurses, midwives and laboratory scientists), a bed capacity of 1000, and a total patient admission turnover of more than 10,000 annually. The hospital offers health services to people residing in the city and serves as a referral centre, especially for cancer cases, from all over the federation; it is referred to as the centre of excellence for oncology. Hospital A conducts approximately 3000 births annually (ABUTH, Health report 2017). It has a capacity of over 1000 beds and a technical staff of over 2000. It is expected to offer higher chances of transferability of the findings to other settings because of its diverse nature in term of service users and personnel. Hospital B is situated in another urban area in the state, about 110km from Hospital A. It was recently given the status of a tertiary institution. It has over 300 technical staff and a bed capacity of approximately 200. It records around 3600 births annually (BDTH Health report, 2017).

The study was conducted in the departments of obstetrics and gynaecology. In each location the department was comprised of three wards, these included the labour or delivery suite, maternity/obstetric ward, and gynaecological ward. Each ward was managed by a head nurse-midwife supported by other midwifery staff, all three wards reported directly to the unit manager/sectional head. The total number of midwives working in Hospital A maternity unit was sixty-seven whilst Hospital B had a total of thirty-five midwives.

5.3. Access to study site

An application letter was sent to the chairman of each hospital's medical advisory committee for permission and access to the two tertiary hospitals' proposed study area. After due consideration, all permissions were granted. An application for ethical approval was submitted to the School of Healthcare Research Ethics Committee and the two local hospitals in Northern Nigeria. This is discussed later in the chapter. See Appendix C and D for the approval letters for access from the two study sites.

5.4. Pilot study

A pilot study involves prior data collection using the planned methods, this is carried out with a smaller sample to test out the approach and identify any details that need to be addressed prior to the main data collection. This is important because it helps to refine data collection instruments in order to avoid or minimise problems during data collection. It also ensures that the questions within the research instruments are clear to participants

(Creswell, 2007). The pilot study process provides the opportunity for the researcher to practise interview skills, observe any strengths or weakness and make changes as required. It also serves as a way of improving the researchers' competency and provides an opportunity for enhancing the interview technique.

The pilot study was conducted with two midwives, the information sheet and the consent form were given to them initially during a previous meeting. The midwives confirmed they were satisfied with the information they had received and signed the consent form. The midwives answered the questions accurately and gave full answers, this increased the quality of data collected and enhanced understanding. Following the pilot study, a decision was taken to adopt a more flexible approach to the interviews. This was discussed with one of the supervisors after the pilot study. There was a recognition that some areas would benefit from adjustment. For example, the approach used for the interview: probing for more details, the gestures used whilst asking questions was noted, and a few sentences in the instrument were then adjusted before the actual data collection began.

5.5. Recruitment of Participants

Following ethical approval from the School of Healthcare Sciences (HCARE) in 2017 at Cardiff University and Hospital A in Nigeria (see Appendix E, G) I met with the midwives at a general meeting, usually held every Monday in hospital A. I introduced myself, described the proposed study and invited questions. Copies of the participant information sheet were distributed to the midwives at the meeting, these contained detailed information about the study. All potential participants were given two weeks to make an informed decision about whether to participate. Once a decision was made to participate in the study, they made contact either by phone or email as stated in the information sheet. Three of the participants made contact and asked that the interview be conducted the next day, they were told that due to the nature of the study only one interview could take place per week to allow for analysis prior to the next interview. They were all excited and willing to participate in the study. The participants chose a date, time and place that would be most suitable for the interview. Posters were also made available at a designated area in the unit, these described the purpose of the study. This idea was to invite more participants who were not available during the briefing at the meeting.

The poster contained contact details for those interested in participating. The participant information sheet was provided to them for further information about the study. The midwives were also contacted as in hospital A, and necessary information regarding the

study was made available via the participant information sheet. Each participant was given a participant information sheet in the English language, this explained the study's purpose, set out their rights, confirmed whether they chose to participate, introduced the interview approach and explained the consenting procedure (see Appendix H.). Following this an interview was scheduled at a mutually suitable date and time. Posters were also made available at a designated area in the hospital B unit, indicating the study's purpose. The aim of this was to invite more participants who were not available during the briefing at the meeting. The poster contained the contact details of the researcher. I was contacted by most participants through text message, they gave details of the most suitable time and place for the interview to be held.

5.6. Sample size and sampling technique

In grounded theory it is essential that enough useful quality data is generated so that patterns, concepts, categories, characteristics, and dimensions of a phenomenon can emerge (Strauss and Corbin, 1998). Therefore, it is paramount to utilise an appropriate sample size to generate sufficient data (Auerbach and Silverstein, 2003). A sample size of 30 midwives from the two-study sites was intended, this was based on similar studies (Thomson, 2011). Sampling and data collection continued until data saturation. Data saturation in grounded theory means when new data generation does not yield any theoretical insights (Charmaz, 2014). It is then assumed that the phenomenon under study has been fully explored (Holloway and Galvin, 2015). The sampling technique was divided into two phases, following the tenets of the grounded theory approach. This includes an initial data collection through purposive sampling, following analysis the theoretical sampling was explored for further data collection necessary for theory generation. These sampling techniques are described in the next paragraph.

5.6.1. Purposive sampling

Purposive sampling was used in the first phase to recruit participants. Purposive sampling is selecting individuals or groups who possess knowledge or experience regarding a phenomenon (Davoudi et al., 2016). Morse (2007) also affirms that grounded theorists begin with a purposive sample of participants identified as having the requisite knowledge and or experience to provide initial information to the area under study. Therefore, midwives who met the inclusion criteria were recruited for the study. Twenty midwives (11 from Hospital A and 9 from Hospital B) participated in the study. It was not possible to recruit the intended number as some of the midwives who agreed to participate failed to schedule the date and time for the interview, this was due to the overwhelming workload

as stated by the intended participants. However, twenty interviews were conducted with the available participants. This could also be referred to as an initial sampling for the study's commencement, when the concept begins to emerge the researcher resorts to theoretical sampling (Charmaz, 2014).

5.6.2. Theoretical sampling

Theoretical sampling is selecting individuals whom the researcher believes will provide information-rich data necessary for analysis and final theory generation (Charmaz, 2014). This took place after the initial analysis of the data generated from the purposive sampling. Theoretical sampling involves collecting further data in the light of categories that have emerged from the earlier data analysis stages (Charmaz, 2014). Theoretical sampling was used to predict where and how the data could be found in order to fill in the niche and saturate categories. Birks and Mills (2015, p.11) suggested that:

“To sample theoretically, the researcher makes a strategic decision about what or who will provide the most information-rich source of data to meet their analytical needs. Writing memos is an important technique to use in this process, as it allows the researcher to map out possible sources to sample theoretically while at the same time creating an important audit trail of the decision-making process for later use”.

Theoretical sampling and theory development continued until theoretical saturation was reached, i.e., when new data do not seem to contribute any longer to new insights, and the relations between the categories were well developed and validated. (Strauss and Corbin, 1990). Theoretical sampling is mainly utilised in grounded theory studies. A total of fourteen interviews were conducted with the same group of midwives, they were also part of the purposive sample. The process of theoretical sampling was adopted to ensure the credibility of the generated theory. In this study those midwives who considered themselves as resilient from the initial data analysis, or midwives described as highly resilient by most of the participants, formed the theoretical sample. Also, it is worthy of note that some midwives in this area could easily self-categorise themselves as coping due to their familiarity with the researcher or for other reasons not known to the researcher. For further confirmation, a snowballing method was used to reach out to these participants until theoretical saturation. Also, from the initial analysis, length of experience appeared to be a key factor; these midwives were sampled in order to include participants representing a range of lengths of experience. The process of selecting and interviewing the theoretical sample is described in detail in the next paragraph.

During the initial data collection participants were asked whether they considered themselves resilient and why. They described a resilient midwife's characteristics and cited examples of some of the midwives they termed as 'coping very well' in the particular hospital. The names of the midwives were recorded in the field diary. However, it became apparent that some of the midwives described as resilient had been interviewed earlier, this was written in the field diary for future reference. Contact was made with midwives who had requested the participant information sheet, and all were willing to participate in the research.

Following the initial data analysis, some of the midwives who had self-categorised themselves as resilient were added to the group of resilient midwives. Their names were noted in my field diary. The analysis also revealed that these midwives had more years of midwifery experience. Previous studies have shown that midwives with many years of experience have developed coping strategies to use in their workplaces (Macdonald, 2010; Hunter and Warren, 2014).

The first midwife described as resilient by the participants in each of the hospitals was approached, she served as a link to other midwives using snowball sampling. The 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.

5.7. Data collection methods

A flexible topic guide was developed (See Table 5.1) from previous literature and the research aims. The content of the topic guides was altered throughout the period of data collection; prompts and questions were added as new ideas and categories emerged. Data were collected over a period of 8 months (Jan - April 2018 and April-August 2018) across the two tertiary institutions. The two phases were conducted one after the other ie phase one was completed before phase two commenced. Interviews were conducted with the midwives, in Hospitals A and B, who met the inclusion criteria and gave their consent. Data were also collected in the form of field notes where necessary. Data collection continued until nothing new came from the repeated interviews, and as such, data collection was terminated in hospital A. Data collection in hospital B commenced following ethical approval in April 2018 (see Appendix D). The use of focus groups was considered, but because of the unpredictable nature of midwifery work and high demands placed on the midwives in their workplace, it was impossible to bring them together as a group for

focus discussion. Thus, individual face to face interview were considered to be more appropriate. Twenty participants were recruited for the purposive samples, this was followed by fourteen participants who were part of the purposive sampling to form the theoretical sample. At each hospital the theoretical sample were interviewed separately, after the purposive sample, until theoretical saturation had been reached.

5.7.1. Using semi-structured interviews

Kvale (1996, p.36) argued that interviews have the potential to 'describe, explain and explore' participants' experiences from their perspectives. Interviews are often used in qualitative research as a data collection method, grounded theorists depend on interviews to understand participants in-depth experiences and feelings about the phenomenon under study (Charmaz, 2014). Additionally, the influence of symbolic interactionism on constructivist grounded theory supports the use of interviews (Denzin and Lincoln, 1998). The use of interviews was particularly relevant to this research because aimed to generate a theory of midwifery resilience using the participants' descriptions of their experiences of workplace adversity and resilience. Using interviews became necessary as it enabled the researcher to explore the participants' views regarding the phenomenon under study. Holloway and Galvin, (2015) concurred that face-to-face interviews also allowed the researcher to observe the non-verbal expression of feelings (through body language and eye contact) to interpret what had been said. It also facilitated the interpretation of emotions, distress, anxiety and silence in data collection and analysis (Holloway and Galvin, 2015).

Using semi-structured interviews, "allows depth to be achieved by providing the opportunity on the part of the interviewer to probe and expand the interviewee's responses" (Rubin and Rubin, 2005, p.88). Berg (2007) put forward that when undertaking such interviews, researchers recommend using an interview guide as this enables researchers to explore areas pertinent to the research. Berg further asserts that one of the advantages of such a guide is that it "allows for in-depth probing while permitting the interviewer to keep the interview within the parameters traced out by the aim of the study" (Berg, 2007, p.39). This ensures that only areas pertinent to the research are explored with the aid of the interview guide. However, Brewerton and Millward (2001, p.74) argue that interviews have poor reliability: "...due to their openness to so many types of bias, interviews can be notoriously unreliable, particularly when the researcher wishes to draw comparisons between data sets". Creswell (2009) also asserts that interviewing reliability is ambiguous and added that no study had documented actual reliable data. However, Alshenqeet (2014) sums up that a researcher should utilise methods that will help

facilitate interview reliability, which includes avoiding asking leading questions, writing field notes, doing a pilot interview; and giving the participants time to clarify answers.

5.7.1.1. Conducting the interviews

After each midwife had agreed to participate, the consent written in the English language (See Appendix I) was obtained before the interviews; it contained information affirming their decision to participate in the study and outlined the data management process which would maintain confidentiality. It also informed participants of the option to withdraw from the study at any time. The midwives provided their consent by signing the consent form prior to commencement of each interview. The interviews were conducted in the English language as it is the language of communication in these settings, each interview lasted between 60-90 minutes.

The interviews commenced with a summary of the study, this included signing the consent form. The participant was then encouraged to give some information about themselves, such as their midwifery background and their practice duration as a midwife in the maternity unit. The reason for this is because the Nigerian nurses' dual qualification nature allows them to practise and work as nurses and midwives. Participants were encouraged to state where they were currently working, this was done to ensure they were working in the maternity unit. This information was sought at the time of arranging the interview. Some simple demographic questions were asked to help put participants at ease, for example, how long they had been practising as a midwife.

During the interviews an open atmosphere of trust and understanding was encouraged to enable participants to feel free to share their experiences and feelings. The researcher tried to be careful not to ask too much or to emphasise any previous traumatic clinical experiences that may have occurred. As the interview progressed it became apparent that all the participants had been exposed to one or more traumatic clinical events. The researcher tried to be sensitive to the participants' gestures, silences, and any slight change in the participant's countenance. There were many times when the midwives would recall a particular traumatic clinical event that would make them emotional. At this point the midwife was asked if they wished to take a break or pause the audio recorder. However, they all agreed that the interview should continue. The midwives were given time to compose themselves and all participants commented that they were happy that someone was interested in studying the midwives' workplace. They mentioned that it was really helpful to talk about some of their demanding work conditions outside their work environment. Following the interview, and prior to the next interview, a debrief was undertaken with my supervisors via skype. The writing of notes and memos was found to

be very useful in these situations and highlighted important points. During the interview the participant's answers were probed. This process encouraged the participants to discuss matters that were important to them. The interview remained focused on the participant's perspective so that the theory that emerged remained grounded in the generated data.

All the interviews were audio-recorded and transcribed verbatim. Notes were also taken whilst talking with the participants, this was useful because some participants gave interesting information that had not been mentioned during the interview. Interviews were transcribed and analysed as they were completed, not waiting for them to be collected as a group. All the stored recordings and analysed transcriptions provided an audit trail for the generated middle-range theory.

Some interviews were conducted in participants' homes, this was a choice made by them based on convenience and it allowed for privacy and confidentiality for the participant. Other interviews were conducted in the hospital in a quiet place where confidentiality was guaranteed. As mentioned previously, each participant had received an information sheet informing them of the study's aims and had completed a consent form before the commencement. This gave the participants time to read the information sheet and consent form and for questions to be answered or points clarified. Participants were also reminded that they could withdraw from the study without any penalty. They were also informed that neither they, nor the hospital where they worked, would be identified and that pseudonyms would replace names.

In this study, the initial three interviews with the purposive samples were rather short, with no in-depth information regarding the subject matter. This was due to the researcher's inexperience; few areas had been left out, but the interviewee's answers were not probed sufficiently to give depth. When the transcripts were reviewed by supervisors using the audio records, areas of concern were identified, and ways of probing further were suggested to ensure rich data necessary for theory generation. This included asking questions such as 'that sounds interesting! can you tell me a little about that' or 'aaahh you mentioned this earlier can you please tell me some more about it?' Perusing the initial transcript was also suggested as a means of finding areas that might have been left out.

Reading literature around the subject of interviewing on a sensitive topic using grounded theory methodology assisted further with the interview process. On listening to the audio recording of the interviews and checking against the transcripts, it became apparent that the interview technique could be improved, this was revisited and questions such as, 'Can you tell me some more about that?', 'That sounds interesting'; 'Sorry, can you please tell

me some more?' were included. These cues are considered very important in constructivist grounded theory as the researcher utilises the interview to be curious about the participant's experiences and beliefs, this entails probing for further responses through intensive or careful questioning. A space of one week was required between interviews to analyse the data generated before the next interview.

5.7.2. Using Fieldnotes

In addition to the interviews, field notes were written at all stages of data collection and analysis. Field notes are 'written records of observational data' (Montgomery and Bailey, 2007, p.67); that is, notes made in direct relation to data collection (Birks and Mills, 2011). Field notes were taken after each interview to describe the participant's non-verbal expressions, my own responses to the interview, and ideas on any vital issues expressed by the participants.

Supplementary field notes regarding body language were documented throughout the research process. The field notes served as a viable tool during the interviews to collect non-verbal communications, this provided a means to gain a greater understanding of the midwives' experience. It also helped me to understand what the midwives said more openly and accurately, as reflected in the data analysis. All non-verbal cues were incorporated into the transcription, as will be seen in interview quotes.

Additionally, physical reactions were recorded to support verbal descriptions. This gave context to the discussions detailed in Chapter Seven, Eight and Nine. In summary, using the field notes enhanced the research process, the richness of the generated data and helped the researcher stay true to the information during data analysis.

Table 5. 1: Interview Guide

<p>Q1. Firstly I would like to know a little bit about you. Can you tell me a little about your career?</p> <p>Prompts: When did you qualify? Where have you practised as a midwife (which clinical areas)? Where do you currently work, what is your role and how long have you been doing it?</p> <p>Q2. Can you tell me what a usual shift might look like?</p> <p>Prompts: How many women might you look after? Do you have a break? How many other midwives might be working in your area at the same time as you? Etc.</p> <p>Q3. Are there aspects of your role that you particularly enjoy?</p> <p>Prompts: Can you tell me a little bit about the women you care for and your colleagues etc.</p> <p>Q4. Are there aspects of your role that you find tough?</p> <p>Prompts: Tell me a little bit about your workload, shift pattern, nature of the work you do.</p> <p>Q5. Can you give me an example of what a tough day might look like?</p> <p>Q6. How do you cope when things are tough at work?</p> <p>Prompts: Are you able to unwind after a difficult shift? What helps you to recover? Do you talk about your work with anyone? Have you always done this?</p> <p>Q7. Are there aspects of your job that makes the hard days' worthwhile?</p> <p>Prompts: What do you enjoy about the work you do? What impact do the women/colleagues have on your day-to-day role? What keeps you going?</p> <p>Q8. How do you think resilience among midwives can be developed / enhanced?</p>
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5.7.3. Recording the data

The interviews were audio-recorded on an Olympus digital voice recorder DM-650. The recordings were transferred immediately after the interviews to a password-protected computer. The recordings were kept on the recording devices and secured in a locked drawer until the transcription was completed. The transcripts were kept on a password-protected computer.

5.7.4. Iteration

Charmaz (2009) wrote that constructivist grounded theory involved inductive-abductive reasoning, this refers to the researcher's iterative process of moving back and forth between data and conceptualisation. It is considered the most critical part of data analysis in this grounded theory method (Charmaz, 2009). Iteration has been described as one of the three main distinct features of grounded theory that differentiate it from other qualitative methodologies, including constant comparative analysis and theoretical sampling (Tie et al., 2019). In this study iteration was used, 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. This study was designed and implemented so that each interview could be conducted, transcribed and analysed before the next interview took place. A span of one week was allowed for further analysis of the generated data and reflection before the next data collection. This was an important consideration when designing the duration of the study. This was also one reason why the data collection lasted longer (8 months) and that some participants were contacted for further clarity on a concept that was unclear. This was to ensure rigour and the collection of rich data necessary for theory generation.

5.7.5. Transcription of the interviews

The interviews were transcribed prior to the next interview taking place and then checked against the recording, each transcript took three or four days to complete. Before the initial coding, some of the transcripts were sent to the supervisors for double-checking against the recording and for guidance. The transcripts were checked and some words such as ahhhh or hmmm were omitted, this was amended and was used as a guide for further transcription. The transcripts were double checked again against the audio records, this was done twice to ensure nothing was left out. Following this initial coding was done and then they were checked again for a third time at the end of the data collection.

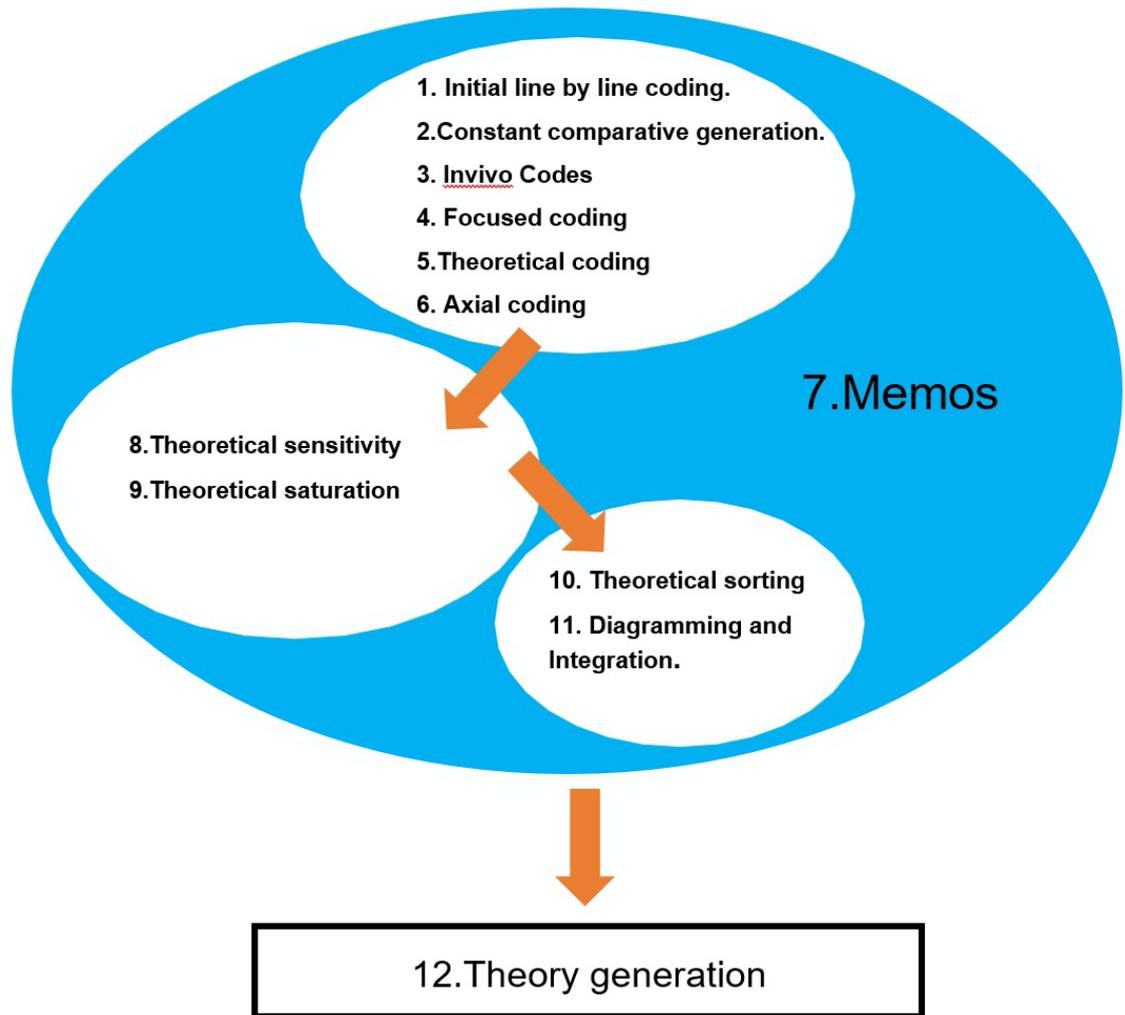
5.8. Data analysis

As Charmaz (2014) explains, data collection and analysis are an iterative process in grounded theory. The researcher is required to move from data collection and analysis and back to data collection. This involves movement between concepts, data and constant comparison across the different interviews in order 'to control the conceptual level and scope of the emerging theory' (Lawrence and Tar, 2013, p.30). The goal of grounded theory is to develop a theory that is grounded in the data. Data analysis was inductive and was dependent on the data themselves as required in grounded theory methods. The audio records of the interviews were listened to and transcribed as soon as possible after each interview. The purpose of this was to keep very close to the data and to start the process of theory generation. Reflexivity was achieved by writing field notes and memos throughout the process of data collection and analysis. Data analysis was conducted using the essential steps required for grounded theory methods.

The essential steps in grounded theory methodology are:

1. Initial coding using line by line codes with gerunds
2. Constant comparative analysis
3. In vivo coding
4. Focused coding
5. Theoretical coding and categorising.
6. Axial coding
7. Memo-Writing
8. Theoretical sensitivity
9. Theoretical Saturation
10. Theoretical sorting,
11. Theoretical diagramming and integrating
12. Theory generation (Birks and Mills, 2015; Charmaz, 2014)

Figure 5. 1: Steps of the grounded theory methodology adapted from Birks and Mills (2015)



5.8.1. Initial coding through the application of gerunds

Saldana (2016, p.4) defines “a code in qualitative inquiry as a word or short phrase that symbolically assigns a summative, salient, essence-capturing and/or evocative attribute for a portion of language base or visual data”. In the same vein, Charmaz (2014) describes coding as a vital link between data collection and developing a theory to explain the data. It is a mechanism that enables the researcher to understand what is happening in the data before the analysis. Charmaz (2014) writes that codes are created from the types of language used by the participants and their actions.

In this study, initial data analysis was conducted using line-by-line coding by applying gerunds. For example, (using improvisation, becoming a super midwife) to give meaning to data closer to participants' perspectives (Charmaz, 2014). Charmaz (2014) writes that

“line by line coding, the initial grounded theory coding with gerunds is a heuristics device to bring the researcher into the data, interact with them and study each fragment of them” (Charmaz, 2014, p.121). Using line-by-line coding for topics and themes via a theoretical framework promotes an in-depth understanding of the data (Charmaz, 2014). Drawing initial line-by-line codes together enables the researcher to sort and synthesise the data. After the initial coding, detailed coding happens in a subset of the interviews, and the rest of the steps may not progress linearly. An example of initial coding is seen in (Appendix J).

5.8.2. Constant comparative analysis

The transcribed data from each interview are reviewed line-by-line (Charmaz, 2014), a constant comparison is then used to search for emerging patterns. At this stage, categories had not been developed. A constant comparative analysis is an analytical process used for coding and category development. This entails taking backwards and forward movements to compare incidents and sections of the data (Birks and Mills, 2015). Similarities and differences between incidents in the data are examined and ideas generated within the category are compared with those that have previously emerged (Holloway and Galvin, 2015). Throughout this process categories are produced, and patterns established to ensure the explanatory power of the categories, this may further help in theory generation (Holloway and Galvin, 2015). Charmaz (2014) writes that the constant comparative method should be utilised at every stage of the analysis to develop analytic power, such as comparing participants’ words within the same interview and between interviews to find patterns and meaning in the data. This leads to theoretical sampling.

5.8.3. In vivo codes

The in vivo codes are also called the “literal codes”, or “verbatim codes” (Saldana, 2016 p.168). According to Charmaz (2006, 2014), codes of participants' special terms are referred to as in vivo codes, and they provide a useful point for commencement of data analysis. They are simply the codes that are named after terms used by the participants. In-vivo codes are a method of coding which takes place alongside line-by-line coding and is integrated into the body of the coding rather than standing alone as a coding strategy (Charmaz, 2014). Examples of in vivo codes in this study is the “Watching each other back”, “Being out of balance”, “Balancing up” “Beating the odds”.

5.8.4. Focused coding

This is the second major phase in coding. It searches for frequent and vital codes from initial codes to develop the most remarkable categories in the data (Saldana, 2016). It involves creating codes that are more conceptual to enable the researcher to move towards theory generation. "Focused coding requires decisions about which initial codes make the most analytical sense" (Charmaz, 2014, p.138). Focused codes appear more frequently among the initial codes. For example, in the initial coding shown, both participants talk about 'becoming a super midwife'. An example of focused codes can be seen at Appendix K. The analytic process of raising categories from focused coding involves the application of theoretical coding. This is discussed in the next paragraph.

5.8.5. Theoretical coding

Charmaz writes that theoretical coding is a sophisticated level of coding that accompanies the focused coding (Charmaz, 2014). Theoretical coding involves putting the pieces of data back together from the initial coding and focused coding, this allows the researcher to make sense of it (Glaser 1992). Using theoretical codes allows the researcher to explain the data and show relationships between the categories developed through focused coding (Charmaz, 2014). Theoretical codes add 'precision and clarity to the analysis'. An example of raising the focused codes to theoretical codes of conceptual categories is shown in (Appendix L).

5.8.6. Axial coding

Axial coding is the highest level of intermediate coding and has been a characteristic of the work of Strauss (1987) and Strauss and Corbin (1990). Strauss and Corbin (1990) wrote that axial coding is needed to investigate relationships between concepts and categories developed initially in open coding, this is similar to initial coding in the constructivist grounded theory methods of analysis. Strauss and Corbin (1998) developed the "coding paradigm to ask questions about the conditions, actions/interactions, and consequences of categories, thus making links between the ideas being conceptualised from the data" (Mills et al., 2006, p.5). Strauss (1987) recommended that a novice researcher use a coding paradigm, which is a reminder to code according to what he calls 'paradigm items' (Strauss, 1987, p.27), such as conditions, consequences, relationships among actors, and strategies.

In the paradigm framework 'causal condition' refers to "sets of events or happenings that influence phenomena" (Strauss and Corbin, 1998, p.131). This means that the causal conditions are those conditions that create or bring about emergent themes. Such concepts may include events or activities that lead to a theme or category (Strauss and Corbin, 1998).

Secondly, 'contextual condition' is defined as 'patterns or sets of conditions' within which the 'action/interaction strategies' of the study subjects take place (Strauss and Corbin, 1998, p.132). The context is the specific set of characteristics in which the phenomenon is embedded. Simultaneously, the context also consists of the special set of conditions in which action/interaction strategies take place to overcome a particular phenomenon (Strauss and Corbin, 1998). On the other hand, the phenomenon refers to the central events in which a set of actions or interactions are directed at. (Strauss and Corbin, 1998).

Thirdly, intervening strategies are the broad and general conditions that influence action/interaction strategies (Strauss and Corbin, 1998). This may be time, space, behaviour. etc. Finally, action/interaction strategies are defined in the paradigm framework as "purposeful or deliberate acts that are taken to resolve a problem and in so doing shape the phenomenon in some way" (Strauss and Corbin, 1998, p.133). Most actions and interactions are performed to answer a problem or overcome a phenomenon, leading to results and consequences (Strauss and Corbin, 1998). The consequences can be real or hypothetical in the present or the future (Strauss and Corbin, 1998). They are usually the result or outcome of actions and interactions resulting from the strategies.

Using the coding paradigm as a framework in the process of a grounded theory analysis has been recognised as a major issue. However, Charmaz (2006, p.61) argued that the framework might be useful to 'extend the researchers lens' and may depend largely on the situation at hand. For this reason, Strauss and Corbin (1988) suggested that it is important to understand the relationship between categories during the process of data analysis before adapting or adopting the coding paradigm linearly.

In this study an open-minded approach was adopted and followed what emerged during the data analysis. Data was collected and followed the lead that the study had taken. At the end of the data collection and analysis, it became evident that the coding paradigm framework might be useful for linking the relationship between categories and developing the middle-range theory. An example is given in the next chapter of the way in which the coding paradigm was used, and a diagram shows how the categories were linked.

5.8.7. Memo-Writing

Birks and Mills, (2015) assert that memos provide details on why and how decisions were made through the process of data collection and analysis, these included sampling, coding, collapsing of codes, making of new codes, separating, producing a category and identifying relationships etc. Stern (2007) provides the analogy that “if data are the building blocks of the developing theory, then memos are the mortar” (Stern, 2007, p.119). This explains how very significant memos are to the development of a grounded theory. Charmaz (2014) further noted that memo writing is an essential step between data collection and writing drafts for the study. It also enables the analysis of codes in the early part of the research process. In grounded theory, Charmaz (2014) contends that the researcher is a co-creator of knowledge during the process of data collection and analysis. Consequently, Charmaz argues that people can only create their own realities, and that researchers cannot recreate a true picture of these realities, a construction of them (Charmaz, 2014,). Therefore, the researcher may need to use memos during data collection and analysis to enhance the transparency of the findings.

In this study memos were very useful in guiding the whole research process and constant comparative analysis. All thoughts, feelings and ideas generated during the data collection process were recorded in a file tagged as memos. All decisions taken during data collection and during the period of data analysis, especially while generating codes and categories, were recorded in memos and reasons for every action were noted. This process helped the researcher stay true to the data during the period of analysis. An example of a memo is presented at Appendix M.

5.8.8. Theoretical Sensitivity

Theoretical sensitivity is closely linked to grounded theory, Glaser (1978) devoted a whole book to this issue. Corbin and Strauss (2015) describe sensitivity as “having insights as well as being tuned into and being able to pick up on relevant issues, events and happenings during collection and analysis of the data” (Corbin and Strauss, 2015, p.78). In the same vein, Tie et al. (2018) write that theoretical sensitivity is the researcher's ability to become aware of a vital data segment that may be useful to the developing theory. Using a constructivist grounded theory involves theorising during data analysis and then pausing to think about what needs to be explored further using theoretical sampling (Charmaz, 2014). Birks and Mills (2015, p.12) noted that “as a grounded theorist becomes immersed in the data, their level of theoretical sensitivity to analytic possibilities will increase”.

In this study theoretical sensitivity was enhanced by reading the literature during data collection and analysis, coding, and category building, remaining flexible and open to data collection and analysis, using reflection in memos, gathering additional data using field notes, writing memos and reading through the transcribed data thoroughly. Consequently, interview guides were amended as soon as further inquiry lines opened to gather more in-depth information.

5.8.9. Theoretical saturation

Charmaz (2014) stated that “categories are saturated” when gathering fresh data no longer sparks new theoretical insights, nor reveals new properties of your data” (Charmaz, 2014, p.213). This means that when nothing new has been identified in the participants’ stories, it can be concluded that a theoretical saturation has been achieved. Once this had been recognised data collection and analysis was terminated, and theoretical sorting (see, 5.9.11) began. As a novice researcher it was difficult to conclude that saturation had been achieved. The participants were informed that further contact might be necessary in order to clarify or further explore some areas of the data, they all consented. As soon as theoretical saturation had been achieved, especially when no new insights had been provided by the last three participants, there was a break so that the entire data could be revisited. The decision was then taken to commence with sorting and diagramming. This process is described in the next paragraph.

5.8.10. Theoretical sorting, Diagramming and Integrating

Charmaz (2014) asserts that sorting, diagramming and integrating memos are interconnected processes. During the analytical phase, memo writing ensures that analysis progresses more strongly, clearly and theoretically. Also, categories have been developed in the written memo and entitled in specific and analytical terms, thus it is ready for sorting. Theoretical sorting is a means of creating and refining theoretical links. The sorting of memos is one of the major processes through which a grounded theory is written up (Hernandez, 2009).

The use of diagrams helps to provide specific images of ideas and further provides a visual representation of categories and their relationships (Charmaz, 2014). Diagramming helps refine the relationships between theoretical categories (Charmaz,2014). Strauss (1987) and Strauss and Corbin (1998), as cited in Charmaz (2014, p.218) utilised “visual images of their emerging theories as an intrinsic part of grounded theory methods”. They used different types of diagrams, including maps, charts, and figures to describe

relationships during the process of constructing their analyses and their completed works (Charmaz, 2014). Saldana (2003) noted that transforming series of categories to a theory occurs through theoretical integration. Integration of categories makes it possible to see whether the categories fit or do not fit. Integration of memos makes relationships between categories understandable (Charmaz, 2014).

During the period of this study several drafts and diagrams were crafted to explain the connection and relationship between categories, these were sent to supervisors. As a novice researcher this was quite challenging, axial coding was thus adopted using the coding framework to help link the categories to the theory's development.

5.8.11. Generating the Theory

A grounded theory study's final product is an integrated and comprehensive grounded theory that explains a process or scheme associated with a phenomenon (Birks and Mills, 2015). A grounded theory's overall aim is to create a theory derived from the data (Bryant and Charmaz, 2007). Theory in the context of grounded theory means: 'identifying the relationship between and among concepts and presenting a systematic view of the phenomena being examined, in order to explain what is going on' (Wiener and Wysmans, 1990, p.12). Charmaz (2014) defines theory as the relationships between abstract concepts targeted towards explanation or understanding. The theory chapter presents the middle range theory generated from the data.

5.9. Rigor and Trustworthiness in Constructivist grounded theory

There is no universal criterion for judging all qualitative studies (Morse et al., 2002). However, generally accepted criteria do exist. As a result, Quinn writes that "philosophical underpinnings or theoretical orientations and special purposes for qualitative inquiry will generate different criteria for judging quality and credibility" (Quinn, 2002, p.542). Thus, different quality criteria are needed for judging different qualitative studies. The generally accepted indicator of quality in qualitative research includes the four criteria proposed by Lincoln and Guba (1985), which includes credibility, dependability, confirmability and transferability.

The criterion for judging grounded theory varies across the three different traditions, but each of the criteria may also be used across. For example, the criteria for assessing the classical glaserian grounded theory is fit, workability, relevance and modifiability (Glaser, 1978). For the Straussian grounded theory, Corbin and Strauss (2008) provided ten criteria for judging the quality of research findings, these included fit, applicability, concepts,

contextualisation of concepts, logic, depth, variation, creativity, and sensitivity and evidence of memos.

In view of the methodology used in this study, Charmaz (2006) provided the four criteria for judging the quality of constructivist grounded theory which included “credibility, originality, resonance and usefulness” (Charmaz, 2006, p.182). They were used to evaluate the quality of the developed grounded theory. The way in which these have been applied to this study is described in the following paragraphs.

5.9.1. Credibility

Credibility is the criterion used to evaluate whether the findings of qualitative research represent a credible interpretation of the data drawn from the participants' perspectives in the research (Charmaz, 2006). In this study, credibility was addressed in the following ways.

5.9.1.1 Reflexivity

Reflexivity was useful throughout the process of data collection and analysis to enhance credibility of the findings. Charmaz (2006, p.188) described reflexivity as a continuous process which involves;

“the researcher’s scrutiny of his or her research experience, decisions, and interpretations in ways that bring the researcher into the process and allow the reader to assess how and to what extent the researcher’s interests, positions and assumptions influenced inquiry. A reflexive stance informs how the researcher conducts his or her research, relates to the research participants, and represents them in written reports”.

Reflexivity was maintained throughout the process of data collection. The reason for this is that some of the midwives working in the clinical areas were known to the researcher. As a midwifery educator, students were frequently placed in one of the hospitals to gain clinical experience. As a result, great care was taken to ensure all activities were documented. The participants were reassured, and it was made clear to them that this was a research degree, and the interviews would be conducted in that context. Whilst past personal and professional experience in research and midwifery practise was useful in enhancing theoretical sensitivity, this experience could influence the research process. Thus, a reflexive diary was used to document all the research activities such as handling transcription issues and synthesis of data and any emotional responses to the interviews. Reflexive journals comprising a series of written notes, reflection, and ideas, were

documented daily throughout the research process. Also, subjective statements and discussions with supervisors were also recorded. These documents provided an audit trail of decision-making processes, relationships with the participants and the relationship with the data (See Appendix N). At the initial stage of the data analysis manual coding was used with the aim of becoming more submerged in the data. Following this NVivo 12 was used to support data analysis. It served as an audit trail and supported in organising the data. Data collection, analysis and memoing were carried out simultaneously until theoretical saturation was achieved.

5.9.1.2 Theoretical Sampling

Using theoretical sampling following analysis of data from the initial purposive sampling methods enhanced the credibility of the study and finally saturated the categories (Strauss and Corbin, 1998). For example, following identification of the resilient midwives using the criteria mentioned earlier, a further interview commenced. This aimed to saturate the category of 'meaning of resilience' and the various resilient strategies under the category of 'managing and thriving category'.

5.9.1.3 Constant Comparison

Using the constant comparison, the credibility of emergent concepts was checked constantly through a coding process. Concurrent data analysis allows data analysis continuously throughout the collection and informs interview guides for further data collection.

5.9.1.4 Triangulation

Using more than one data source (interviews and field notes) provided a means for enhancing the credibility of qualitative research (Bryman, 2008). The two main purposes of triangulation are to 'confirm' data and to ensure data are 'complete' (Begley, 1996; Shih, 1998). These data sources also provided richer and more comprehensive data to achieve a deeper insight into the factors that influence midwives' experiences of workplace adversity and resilience. The two data sources provided a deeper understanding of the subject under study and also provided a means for achieving theoretical saturation.

5.9.1.5 Member Checking

Member checking or validation and independent audit trail are also useful in enhancing the credibility of the data (Bryman, 2008). In the process of respondent validation some transcripts of the interviews were returned to the participants, during the data analysis, for their comments and clarification where necessary. When the theoretical model was developed, a summary of the findings was sent back to all fourteen participants for their opinion on whether the developed theory had reflected the reality they experienced. Additionally, the PhD supervisors checked the coding process for consistency of the emergent codes and categories throughout the research, this has added great value to the final theory.

5.9.2. Originality

Charmaz (2006) describes originality as the assessment of the novelty in research findings. These include insights from the generated new categories and the theoretical importance of the research finding. In this study, originality was assessed by conducting an in-depth literature review at the end of data collection and analysis to compare the study findings with the existing knowledge in the area of study. This is presented in Chapter 11. The contribution to knowledge is also presented in Chapter 12.

5.9.3. Resonance

Using resonance as a criterion refers to judging how well the developed theoretical model can “speak specifically for the population from which it was derived and apply back to them” (Strauss and Corbin, 1998, p.267). In this study, the developed theory's resonance was judged by applying the raw data to the generated model and by a member/participant checking (Bryman, 2008). For member checking, a summary of the final findings was sent back to the resilient midwives. These participants, four each from hospital A and hospital B acknowledged the findings as representations of their experiences in a maternity unit. The research findings' resonance has been explored by presenting to a large audience, including midwives. This was done at several conferences (See Appendix M) internationally with midwife audiences from Nigeria and other countries who found more or less a 'fit' and 'relevance' of the theoretical model and findings to what they had experienced within their settings.

5.9.4. Usefulness

Charmaz (2006) describes usefulness as a criterion for judging the significance of the outcome of the study and the direction for future studies. To achieve this the importance of the study findings and the recommendations for further study are addressed in Chapter Twelve.

5.10. Ethical Considerations

Ethical approval was given by the School of Healthcare Sciences prior to commencement of the study, this ensures good clinical practice in health research. To secure ethical approval for this study, a protocol, participant information sheet, consent form, interview guide and ethics application form were sent to the School of Healthcare Sciences research ethics committee. Following minor amendments to the wording of the application and the addition of how researcher safety will be ensured, the committee granted ethical approval in November 2017. To secure the local ethics approval from the two local hospitals in Nigeria, an application letter was sent to the ethics committee in Nigeria. Ethical approval was finally granted from both local hospitals in Nigeria in December 2017 and April 2018 respectively (See Appendices E, F and G).

5.10.1. Self Determination

All participants were autonomous individuals capable of informed consent. Informed consent is essential to ethical research practice (RCN, 2009). To ensure this, written information about the study was provided to the potential participants in accordance with guidance from the National Research Ethics Service (NRES, 2009). The participant information sheet was comprised of two parts. Part one included clear and concise information about the study topic and specific features of interest, this allowed midwives to decide whether the study was of interest to them. Part Two contained more detailed information about the study process, confidentiality, and data protection (NRES, 2009). Written consent for participation in the study was obtained from the participants without coercion before commencement of each interview. Participants were informed of the right to withdraw from the study at any time without penalty. Participants were free to disclose or withhold information at any time.

5.10.2. Data protection and privacy

The researcher ensured strict adherence to the Data Protection Act of 1998, access to all records and electronic data were password protected. The researcher also ensured all

personal identifiable data were securely held to prevent accidental loss or unauthorised access. Care was also taken to ensure that all data were secured throughout the process of the research. Strict adherence was ensured to the university's procedures for management and data storage of research records (Cardiff University, 2011). With assurances made to participants regarding the secure storage of data, they were informed that anonymous data would be shared with the research supervisors and that the final research report would be published in relevant professional journals.

5.10.3. Confidentially and Anonymity

Pseudonyms were utilised throughout the study where participant's name and research sites were required. Personal identifiable information was kept separately from the anonymised data. The participants were assured of confidentiality prior to the start of each interview. The hospital provided an office where the participant meetings could take place during their break time without anyone knowing. Some of the interviews were conducted at their residence, for some it was difficult to meet at the initially scheduled time for the interview at the hospital. This was to ensure anonymity amongst the participants.

5.10.4. Fair treatment and management of risk

All the hospital interviews were conducted in a secluded place, this assisted with the anonymity of the collected data. The clinical psychologists in the two study areas were informed that their contact details would be provided to the participants who may contact them following the interview. This was felt to be necessary due to sensitive nature of the topic and the resulting risk of emotional or psychological trauma. Participants were informed that if in the process of the interview any harmful practice or unethical conduct was disclosed, it would be reported to the appropriate authorities for necessary action.

5.10.5. Researcher's Safety

The Cardiff University guidance on health and safety was adhered to, including a risk assessment of the interview venue. Regular communication took place with my supervisors via email or skype before commencement of the interview. The necessary steps were taken to prevent exposure to any risk in the hospital environment where data were to be collected. Some of the participants requested an interview outside the hospital area. A close family member was informed of the time and location of the interview and a mobile phone was always carried. To reduce the risk of psychological trauma a reflective

diary was kept to express emotion and supervisors were available for further counselling and debriefing if necessary.

5.11. Summary

This chapter has provided an overview of the methods used in this study. The methods, aims and objectives of the study have been outlined and discussed. The constructivist grounded theory approach of Kathy Charmaz (2014) was used to guide data collection and analysis. This approach was used to guide the methods applied to the recruitment of the midwives to this research and the use of fieldnotes to support the generation of theory from interviews. The coding paradigm was used to create a linkage between the categories. Ethical issues related to data collection and analysis and how it was resolved have been described, these ensured the researcher's safety and that of the research participants with regards to a consent procedure, involvement in the research, and confidentiality. This chapter has also provided criteria for ensuring the quality of a constructivist grounded theory. Chapters 6-9 present the research findings, whilst Chapter 10 presents the generated grounded theory.

CHAPTER SIX - Introducing the Findings

6.1. Introduction

This chapter introduces the finding chapters. It also presents the characteristics of the purposive and theoretical samples. The findings are separated into four categories, these are described in Chapters 7, 8, 9 and finally Chapter 10 describes the generated grounded theory. All findings' chapters have been developed through a careful process of data analysis and theoretical sampling. In the forthcoming chapters, Chapter 7 presents the participants' experiences of workplace adversity and perceived effects of the adversity experienced. This is further categorised into two subcategories: i) Causes of adversity and ii) responses to and perceived effects of the adversity experienced. Chapter 8 presents two categories 'Understanding resilience', and the 'Managing and thriving' which are the resilient responses generated from participants considered as resilient from a careful process of theoretical sampling.

Chapter Nine presents the impact of institutional environment on resilience; this institutional based factor contributes both to adversity and also resilience. These categories are represented in Figures 6.1 and 6.2 in the next section. Chapter Ten presents the generated theoretical model.

This chapter includes an explanation of the way in which the coding paradigm was used as a framework to link the categories. The social demographic characteristics of the participants are also presented. This includes a description of the participants and their characteristics such as their years of practice generally, years of experience in midwifery for participants who are double qualified, work location and their qualifications.

6.2. Using the coding paradigm to link the categories

The 'coding paradigm' was used to represent the structure and process of the midwives' workplace resilience construction and to link the key categories. The coding paradigm differentiates between causal condition, actions/interactions, and consequences. In this study, the 'causal condition' is the 'factors causing adversity' which resulted in 'workplace adversity'. The findings demonstrate the tension and stress within midwifery practice, and the perceived effects of the adversity experienced as a consequence. The context of this study is the hospital setting.

Furthermore, the categories 'managing and thriving' and 'strengthening resilience', also referred to as the 'resilient strategies', represented the 'action/interaction strategies' that

the participants employed to construct midwives' workplace resilience. Other variables such as the solitary reflection and informal debriefing were regarded as the intervening variables, the participants found these to be useful for activating appropriate resilience responses to the adversities experienced. A resilient midwife, having developed resilient strategies, is more likely to remain in the profession. The following benefits may then result: retention of midwifery workforce, the provision of compassionate care to mothers, increased access to skilled birth attendance and a reduction in maternal mortality.

The use of this coding paradigm in the axial coding process enabled the principal categories to be organised in a logical way and the relationships between these categories to be presented clearly. The core category: finding perspective, four major categories, and twenty-four sub-categories were constructed and interrelated by using the 'paradigm' as seen in Fig 6.1. Subsequently a theoretical model was developed with the midwives by refining the codes and the categories. This is presented in Chapter Ten.

Figure 6. 1: Relationship between categories by using the Coding paradigm framework (Strauss and Corbin 1998, p.123)

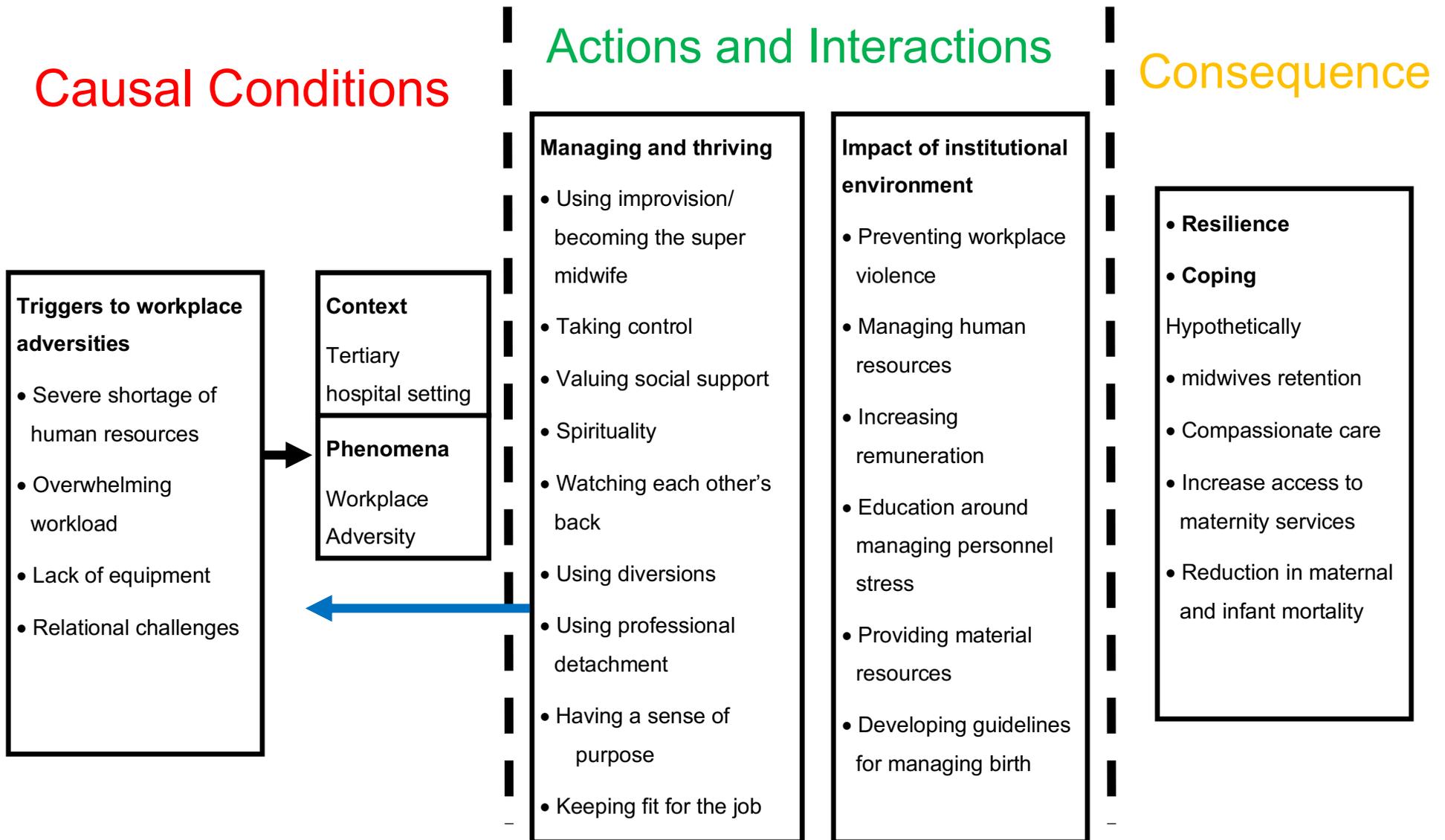


Figure 6. 2: Showing the four categories

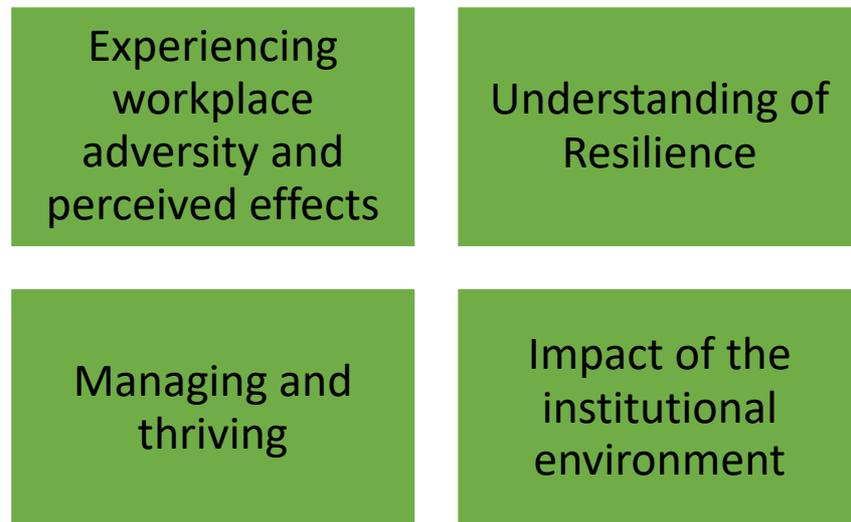
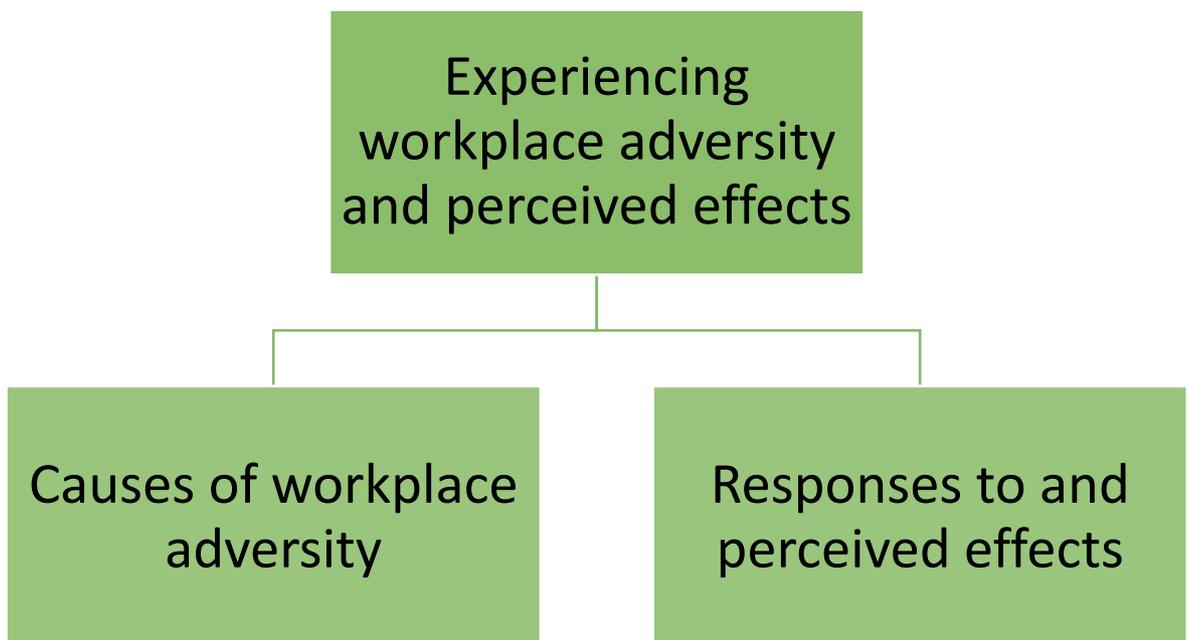


Figure 6. 3: Showing the first category and subcategories.



6.3. Presentation of data

Findings are presented using extracts from participant interviews as well as extracts from memo writing and field notes. However, to ensure clarity for the reader, some of the participants' words will be explained in brackets in the data extracts where necessary. The

data extracts will provide the reader with a deep and rich understanding of the phenomenon under study. Each participant is identified only by a pseudonym to secure anonymity; brackets and three ellipses (...) will replace specific words. Furthermore, some terms spoken in participants' common language is explained in square brackets []. When the participants placed more emphasis on a particular subject matter, this is indicated within a bracket with the word emphasis [emphasis]. In addition, a word or phrase is enclosed in quotation marks when it is an in vivo code and also when it is raised to the level of focused codes.

6.4. Description of the participants

Tables 6.1 and 6.2 provide a summary of the characteristics of the participants who took part in the interviews for this study (purposive and the theoretical samples). The midwives participating in interviews gave this information (characteristics seen in these tables) informally during the interview process, as a rapport was created between the interviewer and the interviewee.

Table 6.1 Characteristics of the participants (Purposive samples)

Part. No	Pseudonym	Years of Practice	Years of midwifery work experience	Name of Facility	Qualification
1	Mary	30-35	10-15	Hospital A	Registered Nurse and Midwife
2	Helen	30 -35	15-20	Hospital A	Registered Nurse and Midwife
3	Jummai	30-35	10-15	Hospital A	Registered Midwife
4	Ladidi	20-25	20-25	Hospital A	Registered Nurse and Midwife
5	Josephine	20-25	15-20	Hospital A	Registered Nurse and Midwife
6	Anna	30-35	20-25	Hospital A	Registered Nurse and Midwife
7	Binta	20-25	20-25	Hospital A	Register Midwife
8	Fatima	25-30	25-30	Hospital A	Registered Nurse and Midwife
9	Linda	10-15	5-10	Hospital A	Registered Nurse and Midwife
10	Deborah	10-15	10-15	Hospital A	Registered Nurse and Midwife
11	Joan	10-15	10-15	Hospital A	Registered Nurse and Midwife
12	Hasiya	5-10	5-10	Hospital B	Registered Nurse and Midwife
13	Aisha	25-30	25-30	Hospital B	Registered Nurse and Midwife
14	Maimuna	5-10	5-7	Hospital B	Registered Midwife
15	Hajara	10-15	10 -15	Hospital B	Registered Nurse and Midwife
16	Bianca	15-20	15-20	Hospital B	Registered Nurse and Midwife
17	Beatrice	5-10	5-10	Hospital B	Registered Nurse and Midwife
18	Nafisa	25-30	25-30	Hospital B	Registered Midwife
19	Mariya	15-20	15-20	Hospital B	Registered Nurse and Midwife
20	Jolie	30-35	30-35	Hospital B	Registered Nurse and Midwife

Table 6.1 above shows that most of the respondents were dual qualified. This means that they are both qualified as a nurse and as a midwife, only few participants were single qualified midwives. The table also shows the number of years in practice and the number of years of midwifery experience. This has been presented in broad categories, i.e. time frame rather than stating the exact number of years in order to protect anonymity. Due to

the nature of the midwifery profession in Nigeria a decision was taken to present these characteristics, this was described earlier in the background chapter as regards to dual qualification. This enables the reader to have a clear picture of how many years the participants have practised as a midwife and provides context for their experiences.

Table 6.2: Characteristics of the Participants (Theoretical sample)

Part. No	Pseudonyms	Years of Practice	Years of midwifery work experience	Name of Facility	Qualification
1	Mary	30-35	10-15	Hospital A	Registered Nurse and Midwife
2	Helen	30-35	15-20	Hospital A	Registered Nurse and Midwife
3	Jummal	30-35	10-15	Hospital A	Registered Nurse and Midwife
4	Ladidi	20-25	20-25	Hospital A	Registered Nurse and Midwife
5	Josephine	15-20	15-20	Hospital A	Registered Nurse and Midwife
6	Anna	30-35	20-25	Hospital A	Registered Nurse and Midwife
7	Binta	20-25	20-25	Hospital A	Registered Nurse and Midwife
8	Joan	10-15	10-15	Hospital A	Registered Nurse and Midwife
9	Aisha	25-30	25-30	Hospital B	Registered Nurse and Midwife
10	Hajara	10-15	10-15	Hospital B	Registered Nurse and Midwife
11	Bianca	15-20	15-20	Hospital B	Registered Nurse and Midwife
12	Nafisa	25-30	25-30	Hospital B	Registered Midwife
13	Mariya	15-20	15-20	Hospital B	Registered Nurse midwife
14.	Jolie	30-35	30-35	Hospital B	Registered Nurse and Midwife

CHAPTER SEVEN - Experiencing workplace adversity and perceived effects

7.1. Introduction

In this chapter the category 'Experiencing workplace adversity and perceived effects' emerged during the coding and analysis phase of data gathering, this took place during the initial interviews and the latter stage of the data analysis. This category describes how the midwives experienced workplace stress. This category is further divided into two subcategories. Subcategory A represents the workplace adversities whilst Subcategory B, explains participants' responses to and perceived effects of the adversity experienced. This is presented in the table below.

Table 7. 1: Category A: Experiencing workplace adversity and perceived effects.

Category A	Subcategories	Focused codes
Experiencing workplace adversity and perceived effects	a. Experiences of workplace adversity	<ol style="list-style-type: none"> 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 and perceived effect of adversity experienced	<ol style="list-style-type: none"> 1. Being abusive. 2. Delivering poor quality of care. 3. Having physical changes. 4. 'Being out of balance'.

7.2. Experiences of workplace adversity.

7.2.1. Working in a difficult workplace environment

Most participants felt that working as a midwife was impacted by several factors. These ranged from dealing with a heavy workload and complex patient case load, to 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 created more stress in their role as midwives. The following data extract is Mary's description of how difficult her work life could be.

A man signed against medical advice and left with his wife, only for them to come back after 3 or 4 days, the woman was bleeding, we were running helter-skelter, [in a disorderly rush] to make sure to address that bleeding we were trying to, we got an anti-shock garment [a garment used to stop bleeding], put it on, did this, we were still on that patient, they brought another patient that was fitting, eclampsia in labour, so I left and went to that one, I was trying to resuscitate, to care, to make sure she does not injure herself and do before we finish that, second one, they brought another patient again Post-Partum Haemorrhage 3, all this complication. So, when these patients with complications comes, it throws the ward off balance [Mary, Interview, Hospital A]

The above data extract suggests that the midwives have the ward 'in control', but when women with complex cases arrive the normal order is disrupted, this creates tension and pressure in the workplace. It also suggests that this order is disrupted when women and their families take decisions which are against healthcare professionals' recommendations.

Similarly, Beatrice also described the difficult conditions in which midwives work. She described having to deal with many obstetric emergencies where women only reported to the hospital when their condition had deteriorated, and the patients' relatives expected the midwives to perform the impossible.

And some days, again one patient can make the place so tough that it won't be funny especially when we have cases of DIC [Disseminated Intravascular Coagulopathy], when you will be running for blood looking for how to save the life of the patient, they are also tough days too, and when we have complicated issue, patient gasping, ahhm bleeding they are almost tough, especially patient that knows they are case of PPH [Post-partum Haemorrhage) and will deliver at home, they rush them to emergency unit.. is not always funny, but once they start bleeding, they start bleeding from the house, probably before they come, the condition will be so bad, and even the patient relative will be there expecting you to do magic (Beatrice, Interview Hospital B)

The data extract above suggests that due to the unexpected nature of workloads, the midwives did not know what to expect nor what might happen. This results in a sudden change in the order of the entire unit and creates a sense of adversity.

The challenge of providing emergency care on top of an already demanding workload was supported by an interview with Anna, she described how stressful and annoying she found the job especially when a patient was brought in late with a complication that could have been avoided. The midwife is then put under pressure while there are other many women to attend to. She told me,

You can imagine there was a day patient was brought in with retained placenta after 24 hours following birth. She was bleeding, and that day I was the only midwife in the ward, the other midwife had gone to get a patient from the theatre, and I had to start running up and down to look for the doctors, on that same day I had two other patients who were already on second stage. It is usually so stressful when this patient come at late stage and also annoying because it is something that could have been prevented and resolved easily when they report much earlier or if they had delivered in the hospital (Anna, Interview, Hospital A)

There is a sense in all these accounts of the midwives' frustration with the behaviour of the women and their families. Most of the midwives also described having to deal with a high patient caseload in the midst of providing emergency obstetric care. They are expected to see all the women almost concurrently. They considered this task as very difficult and contributing to the adversity experienced. Maimuna considered attending to large numbers of patients as very frustrating and confusing and felt that it created a sense of adversity.

Okay, my work load like I said earlier, I said we use to be off balance in this labour room, is not easy we use to have plenty patient in the ward, in labour room, at times they use to be like 10, 15 patients at times, somebody will be pushing, they are calling you in the theatre to go and collect baby, see patient again, plenty patient are lying down for you to check them, they are just coming for you to admit them, eclamptic patient again, at times it is so frustrating. (Maimuna, Interview, Hospital B)

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

2 midwife to like 10, 15 at times 20, at times 20 patient in the night. You are taking delivery, monitoring them using partograph all this things ehee during their puerperal period you take care of them, so is not easy, just 2 midwives and, 10 to 15 patients at times 200 or even more. At times they will be calling you ma, you will even ignore them because several people are on your head. They will say 'sister come', I say, 'sister come', you will just be working sometimes, you will just ignore them and go home (Aisha, Interview, Hospital B)

The midwives also reported that sometimes, with high patient case ratio, it became difficult to provide space to accommodate these women. They further described how the standard of care was compromised. They pointed out that due to high patient caseload, most of the bed space was occupied and 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.

You know it becomes hectic, you see, like the day before yesterday, two days ago, we even have floor cases, yes women delivering on the floor because the delivery couches were filled up, ok, so we never want to push... there is a patient on the couch; you can ask her to come down. So, like yesterday, we had floor cases, we delivered some women on the floor. Am telling you, it is as bad as that (Maryam, Interview, Hospital B)

Participants considered working alone as creating stress, this occurred due to staff shortage. This was typical of many. Helen described how working alone created a sense of adversity, she had multiple roles to undertake with no possibility of handing over. This led to her feeling exhausted and not being able to drive home on a particular day after a difficult shift.

You alone is on the ward, you do admission, you take deliveries, you attend to babies that are delivered, maybe any resuscitation you do it alone....at the end of the day you are tired you will be so tired ...you are trying to deliver a baby.... you are doing some manoeuvre on your own. You get tired. When you finish that day, you have not rested. In the morning you re handing over...you can't even go home...You can't even drive home ...It has happened to me...you can't even go home.....and sometimes you are three ...the same thing happens hmm...if you see it emmm...God almighty (Helen, Interview, Hospital A).

In addition, one of the midwives working in the gynaecological wards commented on how difficult it was to manage wards which were so chaotic and that this was a source of stress. She also reported how midwives had to double up as health assistants, tutors and security officers in order to maintain the workplace. Linda described her experience below which was believed to create a lot on pressure on the midwives:

Because the number of patients we are attending to our role as a midwife, is there, then you work as a Midwife, you work as a security person in the hospital because of the inflow of patients. The health assistants are not many, by the time they go on an errand, or to take patients to various units like Xray, and you are needed in the matron's office (Head of department) you have to go down, you cannot lock the door especially in gynaecological ward because they use it as entrance

to obstetric too. And in the sense of trying to protect the babies from being stolen from the other side, so the inflow of patients, inflow of visitors, inflow of medical personal, is through the Gynaecological ward. So a lot of distraction. (...) We have students also; they needed our attention. You need to teach them. The BNsc [Bachelor of Nursing Science] student comes in, the regular nursing students comes in [The diploma in basic Nursing] the midwives come in and also students from outside ABU teaching hospital premises comes in from other hospitals like (Theesa hospital) they also come into this place. The pharmacist, they also come here for training. So honestly, the stress is great. (Linda, Interview, Hospital B).

Due to the demanding nature of the work, most participants mentioned the inability to go on breaks as creating a sense of adversity. This was described as contributing to the stress experienced. Anna commented that it was difficult for midwives to take a break due to a heavy workload resulting from high patient caseload.

Ahh! It depends. Because once you have a busy day, nobody remembers there is time for break. Because you have a whole day with patients all over the place, you hardly remember that you are supposed to go on break and even when it is not too busy, you are thinking maybe if you are willing to, you will just get up now and mothers will just troop in because within an hour, less than an hour you can find like 4 – 5 women. (...) So going on break. Mtew! I don't think we take break here (Anna, Interview, Hospital A).

For some of the participants, the busy environment of the obstetric unit meant that they felt unable to take breaks as it could compromise care:

No, no break except if we have less patients you can now sit down, maybe drink something then go on because we have others, other women in labour, we need to monitor their labour now take their vital signs, monitor the progress of the labour, then listen to the foetal, then count the foetal heart rate, so you need to do that there is no break! you have to because you want to give proper care we don't have any break, no break![emphasis] [Bianca, Interview, Hospital B].

The lack of breaks meant that work felt relentless, and there was no pleasure or joy in the work, as Aisha described.

Honestly at times is annoying when you are tired, you feel so exhausted so at times the work ... you will be doing it there is no joy in it because you are so tired, you are exhausted, so you will just be doing it ne ka wai [doing the work only with no pleasure attached] just to know that you have done it that's just it, but... is not, is not easy for you not going for break. You just be doing work, work, work, work in the night from when you take over the work till when you hand over the work, you will not

even sit down ... if you sit down is only to write something, maybe to record something..., but you will not even sit down you will be working from night till in the morning, so is not easy, will be so exhausted and tired (Aisha, Interview, Hospital A)

The shift pattern, especially the night shift, was described as difficult. This was attributed to long work hours, around fourteen hours during the night compared to four hours in the afternoon shift and seven hours in the morning shift at one of the facilities. The night shift was also considered challenging because the participants felt that most women presented at night for birth, due to the shortage of staff this placed a high physical demand on the midwives. One of the midwives, Joan, described her sense of the blurring of time when working a night shift, compounded by shift length and increased births.

The night shift, just like I said, is longer and it is more stressful because, you know, it is not easy for one to leave the comfort of her bed, to go a night duty in fact like in this hospital. We don't know the difference between day we don't check time we don't know. In fact from the time, you take over it would be work, work, work it could be 1am, 2am you don't even know what time is it. You will not know that this time is 12 already or 2 already.... so, the night duty is more stressful should I say because of the number of patients that come at night and then the longer time we spent at night ...we spend at night shift more than 12 hours, so it is more stressful (Joan, Interview, Hospital A).

Similarly, Anna in hospital A considered night shifts as very challenging, she felt that this was due to more women needing support with giving birth at night.

I remember one of the days we did night, and we filled up the whole first stage room, second stage room even the examination room... there was no way to attend to a patient. So, they had to start checking, who and who can we discharge, to make space. So, night duty usually is the shift that is usually so hectic, even though the other shifts can be, but most times, the night shift is very difficult. (Anna, Interview, Hospital A)

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, we have to take the baby to SCBU [special care baby unit] before they can get oxygen so me I

prefer, I monitor the foetal heart to make sure it is okay once I notice that the foetal heart is becoming abnormal, I raise alarm to the doctors so that anything that they can do, they can do it as fast as possible you don't have most of the things we require to resuscitate those babies immediately before taking them SCBU (Joan, Interview, Hospital A)

Helen described an experience, below, on the way a lack of such resources creates more pressure on midwives, this was typical of many. She explained that a lack of power supply might get in their way, thereby making the work environment unsafe for the midwife and the baby.

The SCBU [special care baby unit] is just a passage, maybe from the theatre you just go or from the labour ward, you just enter you have to go up -stairs and take the baby, and any time the baby came asphyxiated, that is when another trouble comes because at times you find out, maybe there is no light and you have to climb up, you have to shout for the father or any relation that can shine light for you [provide a light source] you will run and take baby to the Special care baby Unit. (Helen, Interview, Hospital A)

In addition, many midwives also described how lack of availability of appropriate delivery beds results in midwives assuming an awkward posture while attending to birth. They reported that appropriate delivery beds are ergonomically designed, thereby minimising twisted or bent posture while conducting birth. However, the midwives reported that these beds were not available in most of the hospitals thereby making the work even more difficult and stressful. Joan described how difficult it was working in a delivery suite without the normal birth beds, she reported that this created trauma to the back.

Lack of material resources we supposed to have delivery bed. I mean the correct delivery bed, this normal delivery bed [birth bed] is a little bit higher than the normal bed for patients to lie down when they are sick. But if you are now in a situation like in this hospital and many other hospitals, where those normal delivery beds are not available, you now have to bend down to conduct delivery, stressing your back traumatizing your back.... You now discover with time you start having pains, chronic back pain. (Helen, Interview, Hospital A).

The above data extract means that the midwives are exposed to having physical challenges such as back and leg pains with repeated assumption of poor postures while attending births, considering the high patient caseloads and staff shortages. This will be discussed further in section 7.3.3.

7.2.2. Having a poor collegial relationship

One of the difficulties experienced by most of the junior midwives was the lack of support from some of the 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.

The senior midwives and ward managers described experiencing much stress due to their multi-tasking role as a midwife and as an administrator. Often, they doubled as supervisors to the junior midwives and also supported women giving birth due to staff shortages. One of the midwives described how she felt trapped in her responsibilities as a ward manager because of this dual clinical and administrative workload:

Like days when you have too many deliveries [childbirth] and maybe you have another complication that you put in your best. You still have administrative work to do, and you have to combine all of them at the end of the day, you find out that at the end of the day you can't run away from it. You can't run away from them [The administrative role and other responsibilities] (Binta, Interview, Hospital A)

Another senior midwife, Fatima, also described the senior midwives' heavy workload, they work with junior midwives and sometimes the junior midwives may not be available on the ward. This is because they are needed to take women to the theatre, especially women undergoing Caesarean section. Most of the time they are working alone on the ward to support everyone and carry out their administrative tasks due to shortage of midwives.

As I am the senior, the remaining are the juniors and is the juniors that normally go to the theatre. If they are not round Toh! The workload will be much. You must attend to everybody one after the other Continuously, nonstop! (Fatima, Interview, Hospital B)

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.

but some of them [referring to the senior midwives] they will just relax like the senior ones when you are working with them, they will just relax, they will just relax, they will allow you to be doing almost everything, they will allow you to be doing almost everything so you will be so tired, only you they cannot help you to do anything so you will be tired, so exhausted, so that is the negative aspect of them [colleagues] (Maimuna, Interview, Hospital B)

Similarly, Joan also reported how poor teamwork created more pressure on the midwives, especially when working without the support of other midwives who have health challenges. She tried to find an excuse for the midwives (possible health problems) but then admitted that she felt resentful, 'working with grudges and a heavy heart'. She also added how difficult it was working with senior colleagues who felt they were too senior to undertake some of the practical midwifery. They picked up the less stressful tasks and allowed junior colleagues to deal with more stressful situations.

'if you are working with a person (...) that let's say the person is not hardworking maybe because of one health challenge or the other, you will notice that is like I'm working alone and once it's like that, the stress comes too much. You feel you are the only one doing the work and you will be doing it with grudges. Grudges that you are alone while the other person is not working. Especially when you work with some seniors who feels that they had been doing this work when you were not here, it is your own time to do the work... they take the lighter ones, and leave the bulky ones for you, so once when you are doing it like that as you are doing it with grudges, there is nothing you can do, you just have to do it so sometimes you do it with should I say with a heavy heart, and this thing you suppose to, is a work, that is supposed to be done by two people and you are doing it alone'. (Joan, Interview, hospital A)

Lack of confidentiality was another concern identified by the midwives. They reported feeling insecure and not sure about discussing their mistakes or confiding in some of their colleagues due to fear of being labelled as incompetent. Nafisa explained her experience, it created a feeling of being undermined and may add to pressured work.

so, you know some midwives when you work with them, maybe ... they put you through something, then later, you see that they will be gossiping that you don't know how to do it or you should have done this, but while you are there, they will not tell you what to do. (Nafisa, Interview, Hospital B)

This was also supported by a conversation recorded in a field note, Mariya commented that due to bullying behaviour by some midwives she now rarely asks for help if she is unsure. This may have implications for safe practice.

In my interaction with one of the midwives she talked about the problems she is facing with her colleagues. She stated that when she makes a mistake and ask them about how to go about it, that one will be surprised that someone that was not around on the day of the discussion knows about it, because some of the midwives can gossip a lot once you have made a mistake, it is better you keep it to yourself. She added that the last time she confided in one of the midwives she

became a subject of ridicule! That makes her feel scared to talk about anything (Mariya, Fieldnote, Hospital B)

Bianca mentioned that the shortage of midwives may not always be a problem but that lack of support from colleagues makes the job more difficult. She also believed that the way she is treated affects the quality of care she can give, it also affected the way in which the women related to her.

Sometimes it may not really be shortage, it may be that your colleagues are not putting in the way you are putting in at work. So, it affects what you give to patient, and it affect how the patient relate back to you. (Binta, Interview, Hospital A).

Furthermore, some of the participants reported poor managerial support as leading to a low morale at work. Lack of support from the management creates pressure and undermines motivation for work, as Hajara explained:

There are no, there is no motivation at all you will be left alone doing your job, nobody will come and tell you that you are doing a good job, well done! no incentives! no, no motivation! no encouragement from the management [Referring to the most senior hospital midwife] (Hajara, Interview, Hospital B)

Additionally, obstetricians are also expected to support women giving birth where necessary, but some of the participants reported poor teamwork with doctors. Some of the midwives explained that they were expected to conduct both normal and abnormal births with little or no support from the doctors. Josephine explained that she felt unhappy that the doctors were not supporting her, especially in the face of a midwife shortage. There appears to be a tension between Josephine's expectation of the doctors' role to undertake neither abnormal nor normal births if the wards are busy, nor the doctors' expectation.

And you know here at times they tell you this is doctor's procedure; nurse's procedure and they may tell you.... it is not my job as a doctor to do this.... to do that. Just a few of them will understand ...ok, everywhere. Most times a woman is fully dilated to deliver 'Midwife somebody is fully dilated here' of course. You are in Obstetrics and Gynaecology... what stops you from taking the delivery why must it be 'Midwife somebody is fully dilated'. Of course, we are all working here together, what stops you from taking the delivery...they feel that 'ohh midwife' ... They feel they can only come in when there is complication, which I think is not supposed to be so. You understand! [emphasis] They feel like okay, head coming, take the delivery if there is any issue then you call us to me, I don't feel that it's right, we know the working condition we are, we are short staffed. So why don't we help each other? (Josephine, Interview, Hospital A)

7.2.3. Having a difficult midwife – women’s interaction and relationship

The midwives were faced with dealing with the women’s’ relations, some of whom were described as aggressive and impatient. Binta gave an account of her experiences, she reported that some of the women’s relations demanded immediate attention when the patient arrived at the hospital. She reported that the relatives expected the midwives to suspend whatever care they were providing to other women at that point. She explained that they get verbally and physically aggressive and tried to create a scene in the unit 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 the patient, all they want you to do is stop all everything you are doing and attend to them and the patient, if, if you have a case that need more attention than their patient, they will feel like you are neglecting them, you’re not giving them attention so they will become angry and aggressive (Binta, Interview, Hospital A)

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

Yes, yes there was a time I came in to take over I saw patient relatives try to beat a colleague of mine so I had to come in, drag them, even me they were like they won’t listen to me, I was not the one that have problem with them why am I out to come and get myself involve in it they were very, very aggressive, even calling their relatives outside the hospital that they should still come that they are going to, we have to lock that nurse in an office because they are really, really ready to kind of hit her and she was trying to make them understand all they wanted for her is to stop what she is doing because this is an emergency while that case was not really an emergency or we have always have many patient and the patient relative don’t want you to come and tell them that... there is no bed space immediately they hear you saying there is no bed space that is where the trouble will begin, how can you say they’re here with their patient and you tell them that there is no bed space in a hospital like thisthen they will start abusing you. (Hajara, Interview, Hospital B),

Deborah described some precautionary measures taken against workplace violence due to repeated violent or aggressive behaviour by patients’ relatives.

Because if one is proving so difficult, most often we have to ask the security to tell the person to stay away from us, because there are some of them that are very aggressive and we have been changing some of our burglaries [burglaries proof, a special metal door added to the entrance of the ward to prevent access to patients relatives] because of

patients relations that will want to come fighting you at work. Even some of us were even being slapped, and then what do you do, is just at the expense of your job (Deborah, Interview, Hospital A)

This was also supported by an observation field note, Josephine explained that some of the unbooked women (women whose pregnancy was not registered or booked for antenatal and subsequent childbirth at the facility) came with complications. When they reported at the unit, they expected midwives to stop whatever they were doing and respond to their patient. They were usually referred from other hospitals and only reported at term for childbirth. When such women arrived at the hospital, they were informed of the hospital policies and procedures. In particular with regard to the payment of required bills, where to pay them and consultations with the health care professionals, these have to be strictly adhered to. The women's families may consider the policy as difficult and would expect the midwife to bypass these procedures. If the midwife insisted on following protocol, the relatives became aggressive and regarded the midwife as insensitive to the woman's condition. Most of the participants reported that some of the support people were impatient and will not listen to the midwives, this resulted in arguments. The midwives described it as a source of stress.

In my interaction with Josephine, she narrated that one of the problems the midwives also face in the hospital is with those patients that are unbooked in the hospital. She added that they always come to cause problems for the midwives. She added that on one occasion, one of the patient's relative brought a woman in labour and she was the only midwife in, with some of the medical students. The other junior midwife had taken a woman to the theatre for caesarean section, and she was on an eclamptic woman who was fitting. She stated that the patient relative came into the room where she was and said she brought her patient who is in labour. She tried to explain to this patient relative that she was coming as she was attending to another woman. The patient relative came back and told her that she is waiting for her and why is it taking her much time to attend to her, why are we [the midwives] so wicked. she started telling her some harsh work. She narrated that she became so angry and almost wanted to cry. She added that she had to shout back at the woman! that can't you see that I was on another woman? It was a sad day for her. I did not like that. She exclaimed [emphasis] (Josephine, Fieldnote, Hospital A).

The above data extracts suggest that that the midwives are faced with spoken to disparagingly which adds to their frustrations. Participants seemed to blame the women for not booking, implying that they were intentionally causing problems for the midwives. They did not give consideration to the reasons for this.

The participants also reported experiencing distress and anxiety when dealing with difficult births. They described some of the women as being 'uncooperative', whilst they were struggling to ensure the baby and the mother's safety during childbirth. Jummai described managing a difficult birth as creating 'pain and anxiety' and how this was even more difficult when the mother refused to cooperate with the midwife to facilitate birth and no staff were available for support.

Ehmm! So far, so good! The only aspect that gives me pains and anxiety is when you see these difficult deliveries. Some patients are uncooperative patients. 'Push!' They will not push. And this baby is coming with shoulder dystocia. So, it is a difficult delivery, that needs extra hand, your anxiety, you want this baby to come alive, you want the mother to push, the mother is not pushing enough so that you need extra hand to retract, to pull her thigh apart so that we could deliver the baby successfully. (Jummai, Interview, Hospital A)

Participants reported that some women were seen as an obstacle to the midwives, many of them were described as 'not cooperating' with the midwives during childbirth. Hajara also explained how some women became aggressive and interfered when receiving care. Hajara attributed this to lack of pain relief in labour in these settings, resulting in many women experiencing pain. Being in pain, sometimes unnecessarily so, can lead to a very difficult experience for the women, and also for the midwives. Most of the midwives pointed to lack of cooperation from the women, especially during the second stage of labour (when the baby is to be born).

Yes sometimes their aggressiveness and few of them are not cooperating, you are trying to help this women, but she will be the one to tell you this is, this is what she wants to do she will be detecting what she want you to do for her, so sometimes this type of patient are frustrating if you are trying to do your job but she is aah kind of bringing obstacle in doing your job ... so sometimes also they can be aggressive and not cooperative so that give that's kind of gives a negative impact on you, on the mid-wives. (Hajara, Interview, Hospital B)

Negative environmental elements that impacted on midwifery practice, mentioned in the previous section, also affected the interactions between the women and the midwives. Some participants disclosed that negative emotions like anger and frustration due to the heavy workload affected their responses during midwife - women interactions.

Fatima showed self-awareness and empathy for the women when explaining her experience. Fatima reported how she responded to the women negatively and that this affected their midwife - patient relationship.

And due to the stress, you are not able to put yourself in a comfortable position for the patient to be able to express themselves to you. That facial expression could be there and of course the verbal expression. Like you said 'what is it now? What do you want?' [When called by a mother for assistance]. Can you allow me to attend to other patients then I can come back to you?' You know! By the time you decided to come back to them, they must have...[Response from the mother] no need 'I don't have anything to tell you again'. So that kind of thing is definitely going to have an impact on the care of our patients (Fatima, Interview, Hospital A)

This was supported by an observation field note where Josephine gave reasons for patients' aggression during labour. Josephine explained that some women may experience significant labour pain and the routine use of pharmacologic pain relief agents are not widespread in Nigeria. The women are usually irritable while in labour, as a result they may not allow midwives to perform a vaginal examination on them even though the reason is given.

One midwife expressed her feeling on how is not easy to practice as a midwife in Nigeria , and that the most difficult part is because they don't routinely use any pain killer in labour, and some mothers will be very much in pain that they cannot tolerate especially if the baby is at perineum the pain is increased and sometimes if the midwife want to even rupture the membranes or she wants to do VE [vaginal examination] the women won't agree even if you tell them why. They [The mothers] may even scream at you to leave them alone. She started that she feels sad about it sometimes (Josephine, Field note, Hospital A)

Participants also reported receiving verbal insults from both patients and patients' relatives, which was a source of stress and added to their pressurised workload. Binta explained that when providing care to women in labour, some of the women cooperated with the midwives and obeyed every instruction given while others did not. This was felt to be due to the labour pains women were experiencing, as reported by other midwives. However, there are likely to be a number of reasons for difficult interactions which were not mentioned by the midwives e.g., expectations, previous experiences, midwives' behaviour, staff availability, medication availability, social capital, health literacy, etc.

There are some people [Some mothers] when they are in labour, they cooperate. You tell them do this like this, they will obey you. But there are some, they are very aggressive when it comes to birth because of the labour pain. Some can slap you. Yeah, a patient in labour can slap a health personnel, some can kick with their legs. I've seen situations like that. A woman in labour, you want to examine.... you want to perform a procedure before you knew it ... she will just release her legs on you.

Before you know it.. it can hit you on your tummy or anywhere (Binta, Interview Hospital A).

Many of the participants also discussed the issue of caring for women who arrived at the hospital with no childbirth items. A list of these items was given to most of the women during the antenatal period, at first booking, giving them time to purchase the items before childbirth.

However, some women still come to the hospital to give birth without having booked in and therefore have none of the items with them. The items include baby clothes, disposable nappies, sanitary pads, baby oil, drugs, necessary medication, towels, flannels etc. The midwives explained that this created difficulties, they either have to borrow from other patients or use their personal funds to provide for these women. The midwives cited poverty and low health literacy as the reasons for poor birth preparedness amongst these women. Beatrice described the challenge this situation creates for midwives, and it was typical for many of the midwives.

The other challenge is when patient don't get their things complete before coming, so it becomes so challenging especially when you are on night duty and a patient will come to the hospital, she didn't buy pad, she didn't buy anything, so you start ahh! Where do we get this in the night, some of the things the hospital sell, some of them the hospital don't sell, because if you go to the pharmacy you get injections and drugs, but all those things the patient need, some of the patient will come without any clothes for the baby, expecting when they give birth they will go and buy, they want to be sure the baby is alive, so in the night, the woman deliver in the night , in that kind of thing, what do we do, where will they get anything to buy for the baby, we will now start looking for drapes to cover the baby, those are the challenge![emphasis](Beatrice, Interview, Hospital B)

7.2.4. Attending to a traumatic birth

Many participants described how they felt affected by the traumatic births they witnessed because they were, 'feeling for the woman'. It was evident from my interaction with participants' that one of the most difficult times for them was dealing with a traumatic birth, often involving the death of a mother and/or the baby. Midwives reported dealing with many maternal deaths as a major source of stress, they struggled with their own emotions while at work and after work hours. They reported feeling traumatised by loss of life when supporting birthing women. Midwives also reported that due to delays in seeking medical help by some of the women, they are brought in late, and midwives are faced with a challenging situation, working hard to prevent a traumatic birth. 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 [baby born without signs of life], it is painful. I know that for me, and I was feeling very very bad that why should she give birth to a fresh stillbirth that for 9 months she went through, all the discomfort, and then you are given birth, to fresh stillbirth. You know it is painful. And I think the only time I took a delivery of fresh stillbirth, I went home I was so sad, feeling as if I was the cause of that (Mariyah, Interview, Hospital B).

The above data extract emphasised 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.

Ladidi added how difficult she found it to unwind after a traumatic birth experience. She explained how difficult it was to counsel women who had suffered a loss. This is because the midwife becomes empathetic and at the same tries to hide her feelings from the woman. The loss of life was described as a source of workplace adversity.

'But the only thing that puts me off is if a woman that comes with IUFD [intra uterine foetal death] especially primi [primigravida: a woman pregnant for the first time]. First delivery, and you are not delivering a live baby, you know it takes time to do the counselling. You will be so empathetic even though you 'will sympathize with her but, you will keep putting yourself in her shoes, the patient's shoes. You will feel bad.... you would want her to see how bad you felt, but I on my own part, I feel bad. Taking that delivery is and is not a live baby. You will see the girl [mother], or the woman crying at the end of the birth That the first delivery she will have into this world, is not alive, it will take time for me to get over it, the woman's' loss. (Ladidi, Interview, Hospital A)

The above data extract suggests that empathy for the woman's experience influenced the way they interpreted loss of life, and that it meant the participants themselves felt traumatised by the women's experiences. The midwife struggles to hide her emotions whilst at work and finds it difficult to unwind. This experience, together with other difficulties in the workplace creates a sense of adversity.

Furthermore, Ladidi also explained that it is painful if the cause of death is perceived to be due to a delay in seeking medical help as explained in the excerpts below.

Now instead of them [the relatives] like looking for how to bring her to hospital, they left her, the birth attendant kept saying the placenta will soon come out, she kept on bleeding until she was paper white [becomes pale from loss of blood], before they rushed her here. By the time they brought her, she was gone, leaving behind 5 children, it was so painful[emphasis]. (Ladidi, Interview, Hospital A)

Binta also described witnessing the death of a mother as a difficult time, both for herself and other midwives in the unit. She recalled that whenever a mother died, she and all the other staff in the unit became very emotional.

But once maybe they lose a soul, let's say maternal mortality or maternal death or a baby dies, you see everybody is withdrawn [becoming emotional] the staff [Midwives] are withdrawn, the mother is withdrawn and she is the same with other women holding their babies, she will feel bad and her relations too they will feel bad. You don't feel like doing anything. Sometimes we cry, but not Infront of the relations. (Binta, Interview, Hospital A)

The various methods midwives utilised to cope with adversity are presented in the following chapters.

7.3. Perceived responses to the adversity experienced

7.3.1. Becoming abusive

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

Because of the attitude of the patients, because of the uncooperative attitude of some of them, you may see a patient is pushing, the baby is coming out, the patient is trying to close her legs that kind of a thing, that baby might be affected, so you have to at least slap the laps so that the patient will open her legs... after shouting, shouting the patient may refuse to open the legs, you may have to pull it yourself (Aisha, Interview, Hospital B)

According to Jummai, midwives sometimes communicate harshly with women because they fear the loss of the baby. This midwives' behaviour to the woman can appear abusive

and disrespectful, the woman is being threatened that her baby may die if she does not cooperate. This behaviour may be frightening for the women, it may further influence their perception about the midwife and result in a negative childbirth experience. This is described in the data extract below:

So, to avoid the death of the baby, you really have to be very strict in second stage of labour, to make sure that you don't end up with what you didn't bargain for, maybe loss of life of the baby. You do a lot of talking at that stage, then at the end you have to be very strict, you seek for assistance, people can help you. But when you are conducting delivery if the patient is not cooperating... You have to be strict, very strict at that stage, you raise your voice, you look for people to assist, you hold her, you tell her what you want to achieve at the end of the day. 'Don't panic', 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, Interview, Hospital A)

One of the participants justified why aggression is an appropriate reaction to the women. 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 am talking about aggressive, that is when I have to be aggressive, is for their own good not for any reason (Binta, Interview, Hospital 2)

The participants also provided reasons for the midwives' behaviour; this was described in Binta's interview. The midwives carry a heavy burden of responsibility both at home and in work. They explained that a midwife may report to work with stressors from home and this may further influence or precipitate the difficult midwife - patient relationship. Mariyah reported that some midwives became aggressive at work because they have personal issues bothering them, this may cause them to transfer their anger onto the women.

They end up transferring aggression on the person. Sometimes the person has something that is bothering her, and she is now mixing... mixing it with her work, forgetting that she is here because of this patient she now carries her burden now and transfer aggression on the woman (Mariya, Interview, Hospital A)

Participants suggested ways this may be avoided; these will be discussed in subsequent chapters.

7.3.2. Delivering poor quality care

Most of the participants described how compromised quality of care presented a challenge to their beliefs, they felt there was nothing they could do about it. It was observed from the interviews, and some of the field notes, that the midwives felt torn between the ideal of good quality care and the care that they could render. 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.

honestly the care, because we are not much, [few numbers of midwives] so the care we are supposed to give them is not adequate, because of the work load you will be working, working, working so you will be tired so you cannot give them what you are supposed to give them [quality care]. (Maimuna, Interview, Hospital A).

Similarly, Beatrice pointed out that the quality of care delivered to women was poor due to shortage of staff. Not having time to spend with women and listen to their concerns results in the possibility of missing out on important information, this may result in inappropriate care and a poor outcome.

The quality of care hmmm! honestly is sooo poor, is not good enough because, like I say there is no man power, you cannot concentrate on your patient, most times we miss a lot of information from the patient because you have so many patient to take care of, you don't have the listening ear to listen to 'Oh! this is my complain, I have so many pains', one patient will just want you to sit down there and would pour down the whole of her heart, you don't have all the time to do all those things because you have a lot of patient to take care of, so most times the care the patient needs, they don't get it (Beatrice, Interview, Hospital B)

Fatima reported that sometimes the workload was so great that she forgot to carry out vital care, she only remembered during reflection at the end of the working day and felt unhappy about it.

There are times that you think you have finished your work and then you have gone home. And then you remembered that ahh this woman! I am supposed to do something for her, and I didn't do it and then you feel bad about, why, because you were so busy, carried away with other activities that you were not able to do what is expected of you to do (Fatima, Interview, Hospital A).

In addition, Binta reported stress, backache, lack of breaks, high workload and poor material resources as reasons for the inability to provide quality care.

When you are undergoing stress, your back is aching you, you don't have time to go for break, the workload is there, and the material resources are not there. You see after some time or once in a while, you might give out what you are not supposed to give out (Binta, Interview Hospital A).

This was also supported by a field note, Aisha described the delivery suite as one of the busiest places to work as a midwife. She described the delivery suite as a war zone. This is because of the unit's busy nature; every midwife is struggling to save the life of the mother and the baby. She explains that as a result of the heavy workload, midwives tend to rush without paying attention to the quality of care being given and hence may not be delivering the best quality care.

Aisha told me that the Labour ward is the busiest ward in the whole of this hospital after accident and emergency unit. That the midwives just keep rushing to care for the women not bothering on the quality of the care, because the workload is too much. She describes it as being in a war. She pointed to me that, it's so hard and everyone will be depending on the midwife. She started that they can only do their best but cannot give that total care needed (Aisha, Field note, Hospital B).

7.3.3. Having physical challenges

Participants reported that chronic staff shortages and high patient ratio led to a heavy workload, standing for long periods and the inability to take breaks, these present physical challenges to the role. The midwives reported developing body pain, these included chronic back pain and leg pain. Lack of appropriate resources, such as beds with adjustable height for conducting delivery, were considered as a major cause of these problems. For example, midwives explained that bending down all the way to the floor to conduct childbirth resulted in chronic back pain. Back and leg pain was reported as one of the long-term conditions associated with practising as a midwife, for example in Binta's account:

Then some people will end up having complications like backache. It is very common among midwives is very common. Most midwives have backache because of the way they bend down to conduct deliveries so no rest, that trauma to your back can break you down. You see most of us attend physiotherapy session because of our backache. And they are all associated to midwifery service (Binta, Interview Hospital A)

In addition, Jummai reported some procedures (such as suturing an episiotomy) may require being in a bent position for a long period, hence causing trauma to the back which may result in chronic back pain.

if you allow a midwife to conduct that delivery on a bed not meant for delivery, or even in the case of suturing an episiotomy [...] sometimes you may have more than one woman for episiotomy suturing, on top of this there may not be light [power supply], and you have to call on someone to provide a light source for you, then you will now have to bend for a longggg time[emphasis], that is like if the bed is down, you have to over stretch your back. And you can traumatise yourself, you end up having chronic back pain, and if after that delivery you don't visit physiotherapy, so that they can help you exercise the place, to return it back where it is supposed to be (Referring to physiotherapist conducting some exercise on the back) with years you tend to develop chronic back ache which I would say is my own personal experience and why am having this backpain . (Jummai, Interview, Hospital A)

One of the senior midwives explained that she now has a predominantly administrative role, this is due to pain in her back and legs:

Joan talked about her carrying out more administrative roles now and trying to supervise the younger midwives where necessary because she has developed back pain and also leg pain from what she termed as selfless midwifery service. She can no longer participate more in assisting birthing mothers as before, because of the back pain, even though she has been seeing a physiotherapist. (Joan, Field note, Hospital A)

Back pain appears to be one of the hazards associated with working as a midwife, exacerbated by the lack of appropriate beds for the birthing mothers.

7.3.4. 'Being out of balance'

The participants were faced with a challenging workload and found it difficult to achieve work-life balance. This was described as 'being out of balance'. The participants reported fatigue after work and not being able to function properly at home. They explained that their domestic life suffered because they were exhausted after work. Hajara reported that her work life affected her home life, she explained that she did not have time to rest at home as there were so many chores to be carried out. This creates a sense of adversity.

'I remembered a particular day at work, I had a tough shift, it was so, so tough and you go back home you have to cook for your husband, you have children to take care of, you are stress up maybe...emm you slept very, very late in the morning maybe you have issues with your husband, you are angry, so when coming to the hospital you see them looking sad, there is no time to rest, because as I told you earlier that maybe you run a shift and when you go home you suppose to go and rest, you have your house chores, you have somewhere to go, you have husband to take care of, you have your children, you have to go to the

*school pick them up, take them. So, when did you have time to rest?
(Hajara, Interview, Hospital A)*

Similarly, Mariyah described how tired she often gets and that it was sometimes impossible to carry out her domestic chores after work.

You know at such times you have... you can have 20 deliveries in a shift. A woman can go to the toilet to help herself, to ease herself, you end up following her to deliver her baby at the toilet. When you get home, you will be useless to yourself and any other person around you, such time, at that period, I thought, I thought that I will not be able to survive. (Mariya, Interview, Hospital B).

This was further supported by an interview where Hajara talked about the way her work life impacted on her social life due to exhaustion and tiredness from work pressures.

'It's really difficult for me to manage especially when the shift was difficult and was a night shift, sometimes before you get home you may sleeping in the bus, when you get home, you can [be] irritated and you just don't want anyone to bother you. you just want to be left alone. You can't do anything, when you are off you can't even attend parties or wedding ceremony because you have not recovered from the work stress.... you can't manage you home well, everything will be disorganised, except if you are on long night off, which is, which is usually for seven days (Hajara, Interview, Hospital B).

Binta reported that she was so overwhelmed by her workload that sometimes she would get home and find it impossible to do anything more. This was typical of many participants.

The work is very hectic you get so overwhelmed after closing time. Sometimes you are not able to finish your allocated task before closing, so you find out that you will be working oooo [emphasis on the working] till after closing time. but you can't hand over an uncompleted task to the next midwife, you must finish. By the time you are done for the day, when you reach home, you can't even talk to any one because you are tired. You cannot balance up at all! [emphasis]. You discover that when the next day comes, you are supposed to do things but couldn't at home, you discover you are like being out of balance. (Nafisa, Interview, Hospital B)

The various methods of addressing all of the identified adversities will be discussed in the next chapter.

7.4. Summary

This chapter presents the first category of the research findings. The category was further divided into two subcategories for clarity. Subcategory A described the characteristics of workplace adversity, while subcategory B described responses to and the perceived effects of the experienced workplace adversity on the participants' wellbeing. Most of the participants experienced frustration with their workload due to chronic staff shortages, high patient to staff ratio, managing difficult deliveries and obstetric emergencies, difficult shift patterns and managing traumatic births. Also, difficult interaction between midwives and colleagues, midwives and women and midwives and women's support persons created more pressure and a sense of adversity for the participants. Most participants were dissatisfied with the quality of care they provided to the women and their capacity to maintain a work/life balance. The midwives also had to deal with a lack of health and health related material resources, this created more stress for the midwives. The workplace adversity experienced affected the physical, social, and psychological health and wellbeing of the midwives. However, the participants described various strategies they had developed to address some of the identified problems; these are discussed in the following chapters.

CHAPTER EIGHT - Understanding Resilience and Resilient Strategies

8.1. Introduction

This chapter presents findings pertaining to the understanding of resilience by the midwives who participated in this study and the relevant strategies they adopted. Findings from the theoretical sample (see Table 6.2) are presented, these only include midwives who self-identified as resilient from the first round of interviews and who were also identified by other midwives as resilient. They attributed their ability to manage and thrive to a variety of factors. They described how they had built their careers, developed systems of support and become familiar with managerial procedures within the area of practice. They described how their long years of experience enabled them to develop ways to manage and cope in the presence of workplace adversity. This chapter commences by presenting the findings related to the understanding of resilience, this is followed by findings related to resilient strategies adopted by the participants.

Some of the resilient strategies adopted by the participants are also described, these form the third analytic category, 'managing and thriving'.

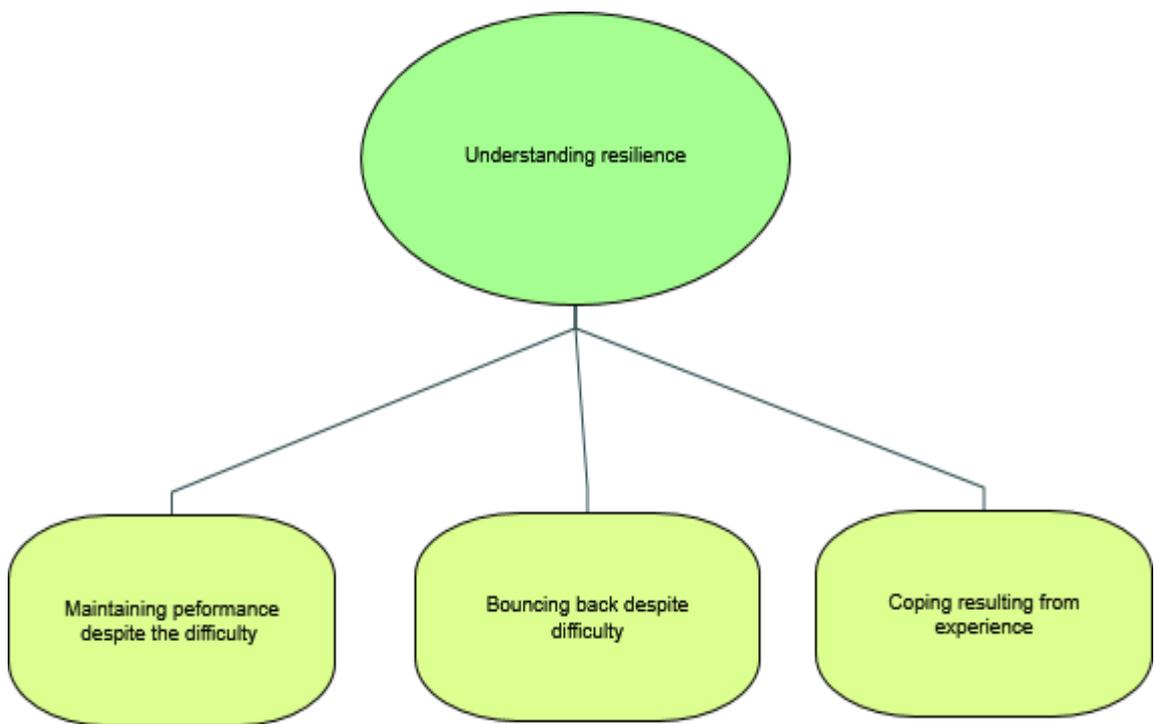
8.2. Category Two: Understanding Resilience

This category encapsulates the way in which participants described their understanding of resilience. It also includes the reasons why the midwives considered themselves to be coping. The interviews began by asking the midwives what they understood by the term 'resilience' and why they considered themselves to be resilient. It became apparent that some of them were not clear about the meaning of the word "resilience". This was defined as another word for 'coping' and it was then understood by the participants.

There was a range of responses and some common themes emerged. Many of the participants considered resilience to be 'coping,' 'thriving,' in the face of adversity. This was hardly surprising as resilience was presented as a synonym for coping. Also, some of the participants described resilience as maintaining performance and providing care despite difficulties. A number of the participants understood resilience to be the ability to cope as a result of experience, this was noticeable amongst participants who had spent many years in practice. Some participants also referred to resilience as enduring hardship while at work. A few of the participants viewed a resilient midwife from the women's perspectives as one who is pleasant and patient with the women and the women are

happy with. The figure below (8.2) shows the focus codes that described this category, these are discussed in the following sections.

Figure 8. 1: Schematic structure of Category two: Understanding resilience and focused codes.



8.2.1. Maintaining performance despite the adversity

The midwives described resilience as the ability to ‘maintain performance’ in the face of adversity. Maintaining performance included giving good quality care to the women. They understood resilience generally as not breaking down and still being able to give one’s best during times of difficulty. Josephine described resilience as ‘maintaining performance’ and in fact, she used ‘being able to satisfy the patient’s needs’ as evidence of coping. This is illustrated in the data extract below:

*Resilience means coping very well despite the plenty of workloads. I hardly break down. I still maintain my performance because I do my best to satisfy these women when they come, and in the end, they are satisfied, and they are appreciative. That is why if I satisfy the need of the patient, I feel am coping, you understand? When I do what I am supposed to do for these patients, despite looking at the demands on us midwife, that means resilience or coping at the end of that day.
(Josephine, Interview Hospital B)*

Hajara understood resilience as not breaking down despite workload and the ability to keep performing in challenging situations. She considered a non-resilient midwife as one that is not able to cope with the workload and thereby requests a change from the delivery suite to another unit or even resignation from service. This is illustrated in the following quote:

If one is not breaking down, that is resilience. I am not breaking down at all, even with the plenty of workloads and shortage of staff because if I am breaking down, it means I will be resigning because coping will be difficult. And that's why, because I don't want to break down, that is why I'm not doing those things that will make me break down; that is why I have the strategies that I am adopting so that I will not break down. Some midwives that can't cope stylishly request to be moved out to other units on health ground or some even resign early because of the stress (Hajara, Interview Hospital A).

Mariya considered coping as not breaking down and not developing any serious health challenges that could prevent her from providing care to mothers. She attributed this as due to some coping strategies she had adopted over the years. This can be seen in the data extract below:

I am coping very well for over 35 years, that is the meaning of coping. I have been giving my best care to mothers, so I am coping because I have not broken down, I have not broken down. All these years, all these years that I have worked in labour ward, I have not had any serious health challenges, I think am coping because of some of the activities that I do [coping mechanisms], so that has kept me going (Mariya, Interview. Hospital A)

Jolie gave an important definition of resilience, which she tried to explain as maintaining a positive 'tempo' of doing work and not feeling tired while providing the best care to mothers. This can be seen in the field note extract below:

She told me that resiliency or coping is when a midwife can maintain responsiveness or maintain the tempo of work and remaining compassionate to mothers, especially during peak period when birthing and work demand is high. She mentioned this act means the midwife is coping, and that the midwife is a strong and resilient person (Jolie, fieldnote Hospital B).

8.2.2. Bouncing back despite difficulty

Most of the participants also understood resilience as the ability to bounce back whilst experiencing difficulties in their workplaces. They describe resilience as coping with difficulties and being able to show concern for the women they care for. Ladidi, for

example, defined resilience as the ability of midwives to give care despite the stress and being able to provide compassionate care to mothers. This is illustrated in the following quote:

Coping is when you bounce back during plenty of work for you in the labour ward. Because despite the stress and the workload and everything, you still gather yourself and bounce back and still make sure you give your best to the patient. It's stressful, but I have a way of not allowing that stress to weigh me down, which will prevent me from giving them my total [my all], so you have to bounce back and still carry out your job (Ladidi, Interview Hospital A).

Similarly, Jolie described a resilient midwife as one who communicates positively with mothers, and colleagues, despite the stress that she is experiencing:

Let me say she is the type [a resilient midwife] that no matter how stressful the work is, you will still see her laughing and smiling, no matter how stressful; you see her laughing and smiling even with patient, she hardly gets angry at patient while some others (...) no matter the stress you still see her laughing, no matter the stress, you still see that smile, that smile is still on her face, and the way she relates, the way she talks to that patient, some people once they are stressed up, their utterances will not be the same way you use to know them before but she (a coping midwife), she maintains, she keeps that laugh, that smile on her face for the patient and her colleagues (Jolie, Interview Hospital B).

8.2.3. Coping resulting from experience

Most of the resilient midwives understood resilience as the ability to cope as a result of experience. They described resilience as being developed through day-to-day activities at work and the experience of dealing with challenges. Aisha, for example, talked about how she learned from her experiences and became more resilient. This is described in the data extract below:

I am coping very well. Yes, it has developed over the years, it is not an over-night thing. Like I have said, now I have spent some years, now in the labour ward. I have seen different behaviours, and each time you encounter such things, you know what to do. You will always move a step ahead; over the years, as time goes on, you get used to these things, and gradually, they become part of you. So that there is nothing new again, you don't see anything strange, you don't find anything new, oh, these are things that I'm used to already, so I know how to handle it, so you find yourself moving forward even amid stress (silence). This is because of your experience, honestly (Aisha, Interview hospital B).

Linda, a midwife in the gynaecological ward, which most of the participants considered being less busy compared to the labour ward, also described at resilience as developing from length of practice. According to Linda, less experienced midwives might not be as resilient as those with more years of experience.

Coping or resilience may not happen immediately, because, like working in O and G [obstetrics and gynaecology] department over the years doing the same thing, taking child birth and seeing the same kind of conditions, one would have been used to all the stress that comes along with it with constant practicing these things should not be tough, except for somebody who is starting new. That is why we need to support the newly qualified midwives. But somebody who has worked over the years with years of experience, she will know how to deal with issues easily. Like me, nothing can be difficult for me here, so I cannot think of anything or anyone that I find tough (Linda, Interview Hospital B).

8.3. Category Three: Managing and Thriving

This category describes the strategies employed by resilient midwives to overcome some of the most challenging situations in their workplace and also how they managed to balance their work life and home life. Participants described how these proactive and pragmatic strategies had been developed or learned over time as a result of workplace pressure and experiences. They explained that they had used these methods to survive throughout their long years of experience. They regarded the strategies as among the most important strategies for managing and thriving in their day-to-day life. This category included descriptions from some midwives about how they needed to become 'super-midwives' in response to some of the challenging periods as a midwife. They described how being creative is important, for example using improvisation when important resources for managing birth were not available.

This category also encompassed various elements of faith and self. There was a frequent invocation of religion, with references to how 'God will reward' all midwives providing support to mothers and neonates. Also, following a traumatic birth experience, participants reported drawing on their faith, attributing death to the will of God, and accepting it. Most of the resilient midwives also reported calling on God for strength daily, praying for safe birthing experiences for the women, and also for strength to support these women through labour.

The participants mentioned the importance of supportive colleagues at work, a few of the participants mentioned the support of a spouse; family they trust whom they can connect with regularly to help them 'offload' and let go of some work challenges. Several

participants mentioned that they used professional detachment as a strategy to deal with traumatic birth experiences. Professional detachment was achieved by moving on from a perinatal or maternal loss and forging ahead with the task in front of them. They also reported the importance of keeping fit for the job, competence, confidence and having a professional interest.

The participants also described the act of preparing women for what to expect of labour and birth during their antenatal visits, they felt this was useful to both the midwives and the women in order to avoid a difficult relationship when the women presented in labour. The participants emphasised the value of building an interpersonal relationship with patients and their relations, they described this as an important strategy which helped to prevent workplace violence. They also felt it created rapport through the use of interpersonal communication skills. For the 'managing and thriving' category the following thirteen focused codes were developed as seen in Table 8.3.1.

Table 8. 1: Showing the Managing and Thriving category and Focused Codes

Name of category	Focused Codes
Managing and thriving	Becoming a super midwife
	Using improvisation
	Taking control
	Balancing up
	Valuing social support
	Spirituality
	Having each other's back
	Using diversions
	Having a professional detachment
	Having a sense of personal and professional identity
	Keeping fit for the job
	Knowing oneself
	Preparing mothers of what to expect of labour and birth.
Building interpersonal relationships	

8.3.1. Becoming a 'super midwife'

The participants reported how they managed to circumvent extremely challenging situations in their workplace. They described how they had to become 'super midwives', looking after four to five birthing women at the same time. They reported that this was necessary due to chronic staff shortages. They also described how they dealt with the situation using a pragmatic approach when the delivery suite was packed full of women in labour.

Mariya recounted her experiences of supporting three to four mothers in labour. She described it as a common experience, especially at a certain period of the year, when births are at their peak:

And sometimes again when we have more than two, three patients, four women, a client may also be pushing, as for me, I normally wear about four gloves, not just double yes! if the place is busy especially during the

period in the year when delivery [births] is high around August, September..ahh ![emphasis] maybe if after collecting delivery [conducted a birth], if I collected a delivery, and another person is pushing, and one has delivered I will just remove the outer layer, discard, already I have sterile gloves still under. I can now conduct another delivery. This is how we normally do sometimes too. Because sometimes, before you remove the gloves and start wearing another one, already another woman is pushing, and the baby might just fall off. So, if you have a full ward, if you have a very busy ward, you get yourself ready for such things, for such eventualities. You have to find a way of becoming a super midwife to solve some of this problem (Mariya, Interview, hospital B).

The data extract above shows that participants were aware of their environment and tried to prepare ahead to help manage situations. One of the participants, Bianca, also talked about some of the strategies she adopted when there were many women approaching the second stage of labour. Like Mariya, Bianca also adopted a pragmatic solution for managing an intense situation while attempting to reduce the risk of infection or cross-contamination. She described wearing five pairs of gloves when she was observing five mothers who were approaching the second stage of labour. The participants reported that, as midwives, they had to find a way of supporting and saving the lives of the mother and preventing injury to the mother or baby.

Five gloves! 'five pairs of the glove,' five here, five here and anticipating the delivery, which one, whatsoever one comes first, conduct this one, deliver the placenta, keep the woman comfortable in bed. Then you go to the next one, continue so that I will not transmit any infection, I don't think there will be a transmission of infection, you will not see blood on the inner glove because I do, I usually remove them carefully, throw them away. Yes! [emphasis] when I have two or more women approaching the second stage, I have to get prepared for all of them. Yes! Prepare my instrument, keep them aside for each patient, then wait for this, complete delivery, then go to the other, the next one complete it, but If am lucky I have one approaching the second stage then, I will be happy then just concentrate on that woman, then complete her delivery, then go on and continue managing, monitoring the other patient in labour (Bianca, Interview, Hospital A).

The above data extract illustrates an experience that was typical for many of the participants; it is a very task-oriented description of 'getting the job' done, this is hardly surprising given the work pressures experienced by several of the participants. The data showed that the midwives became creative, doing the best they could within a limited-resource context.

Participants reported triaging as another strategy used to assist them in dealing with workplace pressures. This was described as a means of prioritising, dealing with emergency cases considered as life-threatening before those considered as less complicated. Fatima reported that amid high patient caseload, she attended to those who were complicated cases first:

If things are tough, you do what we call triage. The one that needs the attention most at each time, definitely the pre-eclamptic, sick mothers, those in labour these two [mothers] that came in are the kind of case that we focused on (Fatima, Interview, hospital A).

Helen reported prioritising complicated births, she described feeling confused and not knowing what to do, especially when there was a heavy patient caseload and insufficient staff to provide support. She reported that she has to do the best she can to save the lives of the women or the neonates. This is illustrated in the data extract below:

If the patients become too much [increased number of women for childbirth], and we are just two in a shift, and maybe the other one [midwife] had gone to get a woman from the theatre, I just attend to the one [mother] that is really bad, before I attend to the other mothers, because sometimes you get confused about not knowing what to do but when you attend to a bad case or a woman with a head at the perineum [baby's head descending at the perineum], you then rush to attend to other women whose case is not bad that way you reduce the pressure on yourself (Helen, Interview Hospital A).

Most of the participants felt that the use of improvisation was critical to midwifery practice. They emphasised that with the heavy patient caseload, poverty of the mother and poor health-care facilities, it was paramount to source alternatives for the required hospital/surgical items within the hospital for the care of the birthing mothers. The participants reported the need for improvisation as being patient-related and hospital supply related. Patient-related factors included the financial status of the patient and her relations. Most of the patients pay out of pocket to get medical treatment and also to buy other hospital consumables as described by the participants. This might cause patients to decline, they may be unable to access potentially life-saving interventions due to lack of financial resources. Consequently, midwives have to improvise in order to save the life of the mother and baby. The hospital-related factors for improvisation are poor supply or even lack of items in the delivery suite, leaving the midwife in a difficult situation. Jolie recounted how she improvised in situations where relatives bring the mothers in and then leave, they do not wait for instructions from the midwives on how to obtain blood for transfusion (a usual routine for mothers not booked in the hospital) due to financial reasons. She recalled how she used an alternative (plasma expander) for blood

transfusion, given the situation where the patient's relatives were unable to pay for blood transfusion. She described how this created a sense of coping because she did what was necessary to save the life of the mother.

And making sure you improvise where you cannot get things as in where it needs to be done, for example, if they say this patient should be transfused, and the relations is just not forthcoming [providing the blood transfusion through blood donation], at times they only come with the patient, and they are gone. So you must get this plasma expander and administer to save the life of this woman (*Jolie, Interview Hospital B*).

Another participant recounted how she improvised and used a pinard stethoscope for mouth-to-mouth resuscitation of the new-born in the absence of a functional ambu bag (a piece of equipment used for resuscitation of new-born babies). She described this experience as creating a sense of coping with workplace stress and saving the life of the baby. She also added that it created a feeling of fulfilment when some of these actions yielded a positive result:

*Most times you do resuscitation, you don't have all the equipment ready, ah I'm trying to remember, trying to do a resuscitation, there was a day we wanted to carry out resuscitation of the new-born, okay, I think is it ambu bag or so for resuscitation, it wasn't functioning, but we were not getting the result, the baby was also asphyxiated. We had to use Pinard stethoscope, as in to do the mouth to mouth for baby to have air, and the baby picked up [responded]. So, when you do such things, and you see that your effort is not in vain, you are happy (*Fatima, Interview, Hospital B*).*

8.3.2. Taking Control

The resilient midwives described several proactive strategies they adopted to remain positive and take control of the workplace stress. A strong theme of division of task or job allocation emerged from discussions with many participants. The resilient midwives described the importance of task allocation, the midwives worked together in each shift. They described it as organising the work in such a way that every midwife carries out the allocated task assigned to them, thereby reducing the adversity experienced. Anna reported that when the work was divided between the midwives, it reduced the stress on the midwife by allowing them to focus on one task at a time:

When things are tough in the ward, it's always a kind of division of labour, and that is how you organize yourselves. It is not that the stress is not there; it will be less. That is why we have job allocation. This job allocation also reduces stress for the midwives. With our job allocation,

you will be able to concentrate on an area and be able to work better than going around the patients haphazardly. You see, when job allocation is being done on the wards; the nurse[midwife] would then act based on an allocated tasks in the ward you still do other tasks outside the allocated task later, but at least you concentrate more on that area you were allocated to; that is one way of reducing stress and coping (Anna, Interview, Hospital A).

Most of the resilient participants reported that they ensured all tasks were completed before handing over to the midwives on the next shift, this reduced the pressure on their colleagues. Binta reported that she tried to ensure that tasks allocated to her were carried out before the next shift, even if that meant staying on after the end of her shift. This reduced the workload of the midwives working on the next shift and was a way of managing the future stress of their colleagues.

You just have to find a way of getting your work done even if it means the other midwives in shift have left the next midwife is coming to take over from you. You have to do all even if she comes to take over from you; she has to wait for you to fix and finish your shift then before you hand over to her. This usually helps reduce the stress on us (Binta, Interview, Hospital B).

The participants also said that one strategy for overcoming adversity was planning tasks and getting the equipment ready in anticipation of childbirth. They described this action as helpful in reducing work pressure when the unit was very busy with mothers in labour. Jummai spoke about how useful and important she found getting birth items ready beforehand, replacing items after they have been sterilized to reduce stress on the midwife:

Most times, we get our things ready, for patients that might come in the second stage, already when they come, we get the things we use from the sterilizer and maybe later in the day they replace, so that is how we cope (Jummai, Interview, Hospital A).

8.3.3. 'Balancing up'

The word 'balancing up' was the participant's way of saying keeping home concerns for home and hospital concerns for the hospital; that way, things get balanced. Most of the resilient midwives emphasised the importance of balancing home and work life. They described how necessary it was to leave hospital issues at the hospital to reduce stress, while also managing their home life. Linda reported finding solace in switching off, she tried not to take hospital issues home, this gave her time to recover and prepare for the following day.

I always try as much as possible not to take anything official home. Because I want to rest, and that is the only way I could switch off by not discussing what happened at work, and that makes me better and ready for the next day's job (Linda, Interview, Hospital A).

The above data extract shows that Linda thought that switching off and not even discussing work at home was essential for recuperating after work. The phrase 'balancing up' was commonly used by the participants, for example in a discussion with Hajara as reflected in a field note extract below:

She narrated that being a midwife in the tertiary hospital is not easy anywhere [in any hospital], it's a difficult thing, especially during the seasons where childbirth are more, she gets exhausted from work before she gets home, but once you can balance up and not to take the stress home, by concentrating at home when you get home, and taking one's mind off the hospital, you will be more relaxed, and stress will be less (Fieldnote, Hajara, Hospital A).

The above field note extract further illustrates that there is a period in the year when the birth rate is at its peak, especially in a tertiary health institution. Midwives are trapped in the daunting and exhausting nature of the work; they are faced with high physical demands resulting from the large number of patients in their workload. Hajara highlighted the importance of leaving work at work to be able to participate in home life fully. She described how this action promotes rest and recuperation from work stress.

Mariyah reported that another way of overcoming workplace adversity was by discuss work issues with colleagues at work. She felt that debriefing was an important strategy for leaving issues behind at work and reducing the burden following a traumatic birth experience. She also described reflection with colleagues as being useful, this enables her to concentrate on home life when the working day has finished. She further described the home front as another 'difficult workplace', where the entire family depends on her for support, it is helpful to leave all negative experiences behind in the hospital.

What I usually do is I don't take hospital issues home at all. The only thing I do is when there a loss of life during my shift I discuss with the other midwives in the other shift when they come on duty. I explained how it happens. We talked over it. it makes me feel better, and after that, I leave everything there in the hospital and go to my house. I don't carry it home at all because home is another difficult workplace. There is another stress waiting for me at home, the kids and housework, and even my husband will have return from work; then, the stress will be much on me. So, I don't discuss any bad experiences, especially after work at home (Mariya, Interview, Hospital A).

8.3.4. Valuing social support

A few of the resilient midwives mentioned the value of social support from family members, they considered it to be an important mechanism for promoting workplace resilience for midwives. They recounted their experience from social support as creating less stress and enhancing both physical and psychological health. Some midwives also talked about the value of gaining support from their family members and husbands, especially after a difficult day. In Binta's interview, she described the value of being comforted and supported by her immediate family members, for example by providing a conducive environment to ensure rest and sleep:

At times you see they encourage me. My family members, my husband, he said ok now, my wife, you have tried. At times they give me a sort of words of encouragement. At times he even taps my back and says, ahh! My dear, you tried today, you need rest. Sometimes the children will say oh mummy had a very hectic day today don't disturb mummy let her rest. Eh! So, my family members, they encourage me and also creates a space for me to rest and then I will get up more relaxed for the next day's job (Binta, Interview, Hospital A).

In addition to these, a few of the participants recounted discussing their experience with their family members to enable them to gain perspective. Mariya recalled how she sometimes discussed her experiences at home with her husband or other family members, especially when there was no time to share them with work colleagues before the close of the day. She described this as useful, helping her find perspective, as described in the data extract below:

Uhm At times, I tell my young ones, or I tell my family that I had a very hectic day today, and they say what happened? I tell them the story I say this is what happened. They will say ohh! What a day! You shouldn't do it alone and your family members, once in a while, discuss with them the challenges you are having, and they will even encourage you and make you see it in another way. It will make you stronger by the time you are coming back, [resuming work the next day] you will come back better for the work ahead of you (Mariya, Interview, hospital B).

Joan also commented on her experience of being supported by her extended family members. She described the stress she experienced at work and recounted how family members supported her whilst at home, they encouraged her to relax and sleep after work and this helped her to control stress more easily.

My husband and in-laws are living with me whenever I am stressed; they support me when I feel tired even before I get home, I let them know the situation of my work that day. Before I get to know they have

made the whole place convenient for me, and they encouraged me to take some rest, and that helps me a lot to cope and control the stress from work, and It helps me a lot to prepare physically and emotionally for the next day challenge at work (Joan, interview Hospital A).

The above data extract illustrates the value of gaining support from family members. Family support is useful in promoting coping, it provides an understanding response and a comfortable environment for rest and sleep. The stronger the midwives feel physically and emotionally, the easier it is for them to overcome challenges at their workplaces.

8.3.5. Having a sense of spirituality

Most of the resilient midwives mentioned spirituality as one of the strategies used to cope with job stress. The feeling of spiritual connectedness was manifested irrespective of their religious affiliation, through spiritual practices such as praying or reading the Quran or the Bible at the workplace and at home. The essence of these prayers was described as a means of connection to faith for strength to cope with workplace adversity. These included features such as seeking help from God during difficult times and asking for God's intervention to save the lives of mothers under their care. The belief in the reward from God, irrespective of their faith, was perceived as tension-relieving among these resilient midwives. The participants also believed that the efforts of the midwives would be rewarded in the hereafter, and this was a source of strength for coping with work pressures. Joan described how she dealt with stress through spiritual connectedness by praying and asking God for help during difficult times. She also expressed how her certainty that God will reward all efforts encouraged her to cope with the stress of the workload. This was described in the data extract below and was typical of many:

I will say it is a work that I know I must work, and I know this work [providing care to all mothers] as a midwife is only God that will reward me. I do it with my heart and mind, so I don't get tired, and I know that when I get home, I pray for God for support, and God has been helping me to cope with stress (Joan, Interview hospital B).

Participants also reported that spiritual and religious beliefs had a positive effect on midwives by providing resources for coping and affecting the individual's perception of the event. Many midwives described how their belief in a superior being as the cause of death created a sense of coping during a traumatic birth experience and protected them from the psychological effects associated with such experiences. Jolie recalled an experience, she felt traumatised and had cried with a woman after witnessing the birth of macerated twins. She added that the belief of death as an expression of God's will was a source of strength in such periods:

Like I was saying to you when a woman dies, or a mother loses a precious baby, it is usually painful for most of us here. Some of us cannot even hide our tears, I remembered one woman who had been trying to conceive and got pregnant after fifteen years from the history she gave us; She had a twin pregnancy; we don't know what happened. The babies were delivered macerated stillbirth [a type of foetal death]. I felt very bad. I didn't even know when I shed tears. But I remember that it was God that gave her those babies, and they are all trials from God for these couples. I just reassured the woman and tried to console her. I was very sad, but my faith helped me a lot during this period to calm me down and also to continue my work on that day (Jolie, Interview Hospital B).

The above data extract shows that, for many participants, a belief in God served as a major source of coping following a traumatic birth experience. Some of the midwives also considered midwifery as a calling and as a way of worship and felt obligated to give care despite the stressful nature of their work. The midwives reported drawing from this inner religious connectedness in the face of adversity. Hajara, who was a ward manager of one of the units drew strength from the perception that midwifery was a way of worshipping God and recommended other midwives to consider it so, in order to cope with the burden of stress associated with dealing with the women:

I always tell them [other midwives] we should consider this job always like you are going to the mosque to pray and or going to the church to pray if you go to the church to pray for God to lead you in his ways, is like the same thing, this souls we are saving here is part of God's work we are doing (...) this work we are doing here is more important than you going to the church because it is the same God we are serving here (...) This work we are rendering here is the work of God practically, by saving the lives of these women. If you allow that soul to die, you will be held responsible by God at the end. if you are passing through hard time pray to God for guidance, if you put this in your mind, thoughts in your head will keep you very active and strong during tough times (Hajara, Interview. Hospital B).

In addition to this, Jummai added that the junior midwives should be counselled to consider midwifery as a divine calling to enable them to cope with the stress. This was believed to create a sense of coping because supporting birthing women through the birthing process is considered a divine act:

I think for the new Nurses [midwives] You would counsel them to look at midwifery as a divine calling. As a midwife, you are called to serve humanity, and you ensure that at the end of the day, you have served the community by bringing forth a live baby and mother into the world through your help. So, no matter the stress of the work on you because

you see it as a calling, you don't feel tired, you want to give more and your best (Jummai, Interview, Hospital A).

In another field note extracted from a discussion with Aisha, she explained that God would reward the midwifery act, she considered it as an important reason for her decision to accept being posted to work in the delivery suite and remaining in the obstetric and gynaecological unit:

She told me about her decision to be posted to the delivery suite, and the decision to stay in labour ward was mainly due to the belief that in midwifery you assist women in bringing in life and she acts independently without even the support of doctors that brings a lot of joy to her. She stated that the decision to remain in the ward is because of the reward from God for caring for women at such a period. She added that because she can also practice in another Nursing ward because of her double qualification. But God is keeping her in this unit to help other women (Aisha, Field notes, Hospital B).

8.3.6. 'Watching each other's back'.

There was universal agreement about the importance of 'watching each other's back' as a key strategy for survival during adversity. Participants emphasised the importance of effective collegial support as beneficial to their sense of coping and wellbeing during a difficult period, including informal debriefing following a traumatic experience. The participants noted the importance of having a supportive ward manager, this contributed to the development of a sense of coping with and surviving workplace adversity.

Mary described how working with supportive colleagues was reassuring and created a sense of coping:

Working with other colleagues that are cooperative is soothing and helpful because we work as a team (...) sometimes you will need something; you do not need to run around yourself. You call on one of them [midwives] and quickly before you know it. Because they know the business [busy unit] in there, you find that everybody is smartly working around and supporting you, especially when the labour room is really busy (Mary, Interview Hospital A).

Informal debriefing with colleagues was frequently mentioned by the midwives after a traumatic experience or difficult birth. The midwives pointed at the importance of being able to talk over a difficult birth with those who knew and understood the way things were from experience. They considered this as pertinent in helping them overcome feelings of low self-confidence. Most participants remarked that positive support received from colleagues was very valuable when they had experienced stressful events or begun to

doubt their midwifery skills. Hajara recounted her experience of talking to a colleague during breaks after supporting a woman who developed a postpartum haemorrhage. They used this time and space to debrief about the events of the day and ongoing issues before going back to the unit.

There was a day I delivered a mother who had a post-partum haemorrhage. I was scared and thought I was going to lose the woman after administering misoprostol tablets and doing other necessary things, but she continued to bleed. Sharing that experience, I had on a particular delivery with a senior colleague at break time was good to me some [senior midwives] if they have anything to contribute, they will share it with you, and you know what to do next time and that will make one feel better and confident when next it happens (Hajara, Interview, Hospital A).

The above data extract suggests that sharing the experience with senior colleagues helps build knowledge and improves confidence, hence promoting coping at the workplace among midwives.

Joan recalled feeling motivated as a junior midwife when she was supported and nurtured by senior midwives, who she believed were trustworthy and reliable. Support from senior midwives built her confidence and enhanced coping for her during tough times. She also described the giving of emotional support to others, as well as being supported by others during difficult times, these were rewarding experiences for her. She described nurturing other midwives as satisfying because she believes they are 'in the same boat':

She told me about how she felt while she was a newly qualified midwife and the importance of been supported by the old midwives in the profession. She describes the nurturing of a newly qualified midwife, especially from a trusted old midwife, as useful and helps confidence and coping with the job. She admitted talking to the senior colleagues as useful. She also stated that she found supporting other midwives and helping them out during difficult times as satisfying because they are in the same boat and that 'watching each other's back' becomes necessary (Joan, fieldnote, Hospital B).

In the extract below one of the senior midwives describes how she supports midwives. Aisha, who was the head of a unit, emphasised the importance of supporting midwives, she described women as having to take charge of two workplaces, the home front, and work. Sometimes, stressors emanating from home life may affect the individual functioning at the workplace. She recounted that whenever she noticed any midwife with a low mood, she approached them and offered support. She added that a midwife might need to be away from work to help her deal with the identified problem. Aisha recalled how she spoke with a midwife colleague who was getting unnecessarily tense and

aggressive for no apparent reason. She described the way she supports them during such periods to promote resilience:

There is no physical or physiological rest properly, so when they are coming back for the next shift you see them looking very sad and depressed so immediately you say something they will just flair up. They will become aggressive so when you sit down with them and tell her not to worry about her task at that moment, you can even tell your colleague [the midwife] to sit down you will go and do her job or assign someone else to do it, so that she will relax for some time, because she has been very busy the previous day, so some times with no reason because the work is tough they are stressed, and you know that there are sometimes with no reason a midwife can become aggressive, so when you observe that she is going towards that point of being aggressive, you have to find a way to talk to her, because she is your colleague you know how to talk to her, you calm her down before she even sees her patient. So that transfer of aggression will not be on her patient, you have to tackle it before she starts going to the patient], and after some time, she is relaxed and returns to work (Aisha, Interview, Hospital B).

The above data extracts show the importance of a supportive ward manager paying attention to other midwives' wellbeing, thereby promoting coping at the workplace.

Anna reaffirmed the importance of having a supportive ward manager who is ready to help during difficult periods. Anna recounted how she felt supported during a challenging period when she had to deal with a personal issue:

Honestly, the colleagues I have here, are wonderful family, I call them a family because, everybody is like a family, when we come to work we chat, we laugh at least you don't carry the problems in your house to work when you come they will cheer you up, and you will be so happy working, is just that is so stressful, but at least we are together, and especially the in charges [ward managers] they call you in term of if you have little problems, complaints you lay it to them, they tell you what to do, there is a way they can help you, they will help you, there are times, my son will be sick I will come to work, I will be so moody I will be crying, in charge [the ward manager] will tell me, what is it tell me, what happen, ahh my son is not feeling fine, and she will say you cannot be sick and then be taking care of sick people, go home and take care of your son, at least I will be so happy and go home and take care of my son and other midwives might be called to support me from another unit (Anna, Interview, Hospital A).

Jolie, one of the resilient midwives with 35 years' work experience, explained in detail how she and other midwives consider each other in the workplace through planning, thereby creating a sense of coping with adversity:

Like after the round or during the round (obstetrician rounds) you know those mothers for surgery, immediately you start preparations so that if they do it in that shift, the next shift will not suffer. The midwife on the next shift is to take the patient to the theatre (Jolie, Interview, Hospital B).

8.3.7. Using diversion

Most of the midwives employed the use of some actions for overcoming stress and reducing its impact on physical and mental well-being. Actions used as diversions included listening to music whilst at work, or after work, and using humour. Bianca emphasised how important listening to music was to her, it appeared to be a form of relaxation during challenging periods and enabled her to cope with work stress as a midwife.

Halima: You mention listening to music, can you tell me more about it?

Bianca: Yes, in the ward. Before you leave, when the whole thing is going on [when the ward is extremely busy], I put it [music] so on low tone at least, I listen to music while at work so little by little, it takes my mind away from the stress. Then when I leave the ward when I am driving home and like when I am coming to the ward this morning, I just put on my music as I am coming, so with that in your mind and the music was playing in your mind too. It helps you relax and gets your mind off the ward! So seriously, you have to develop a way out; if not, you'll break down (Bianca, Interview, Hospital B).

Having a sense of humour was emphasised by many midwives. Many of the participants explained that humour is used adaptively during working hours and difficult situations, it served as a buffer to negative emotion emanating from the workplace. They mentioned that using humour helped detach or distance the self and also fostered group cohesion and social support among midwives, this enabled them to function effectively in traumatic circumstances. Josephine recalled the importance of seeing the humorous side of a difficult experience. This is illustrated in the data extract below:

We are all happy working together, even though is tough we have to make fun out of it because when the going goes tough, we use to make fun or create a sense of humour out of it so that we will not be sad or depressed about the work and it will take our mind away from the situation. I am very good at cracking jokes; in fact, most of us. Because it makes us derive pleasure while doing our midwifery thing or our work and we are using it to ease the pressure of work (Josephine, Interview, hospital B)

Midwives who have a good sense of humour were perceived as coping very well with stress and being more resilient, this was true for many of the participants. Binta emphasised her belief that using language that midwives understood, in order to create humour, made the shift more interesting and this reduced tension at work:

And at times, I make it feel humorous. Like they know me very well, laughing. I have one language I always make; when we are under stress, 'komin Nisan jifa kasa zata sauko'[no matter how far a stone is thrown it will still definitely drop to the ground] we have come to work for some number of hours, and after that time, we will go home and rest in our homes. I will tell them, and you see everybody laughing. When you laugh over it, it tends to reduce the stress we are undergoing. Mm! just to make it humorous.it will relieve everyone from the tension in the air, and the more midwives can use her sense of humour; during this period, the more the stress can be reduced, and they can manage well as midwives (Binta, Interview, Hospital A).

8.3.8. Keeping fit for the job

Most participants reported that physical exercise was very significant and useful for dealing with workplace stress. They recounted that engaging in deep breathing exercises during shifts and after work helped to maintain the work-life balance and promote well-being and resilience. Anna emphatically stressed the importance of exercising for midwives. She felt that engagement in frequent exercise enabled her to remain fit for the job and prevented some of the workplace hazards such as back or leg pain. She reported that she encouraged other midwives to engage in routine exercise:

Like for me, what I do, I told them [other midwives], I do exercise at home so that I will have the strength. When you see me doing this [working hard], I said I do exercise at home so that at least I can be fit, but some of them are saying, it is true, ooh! We need to do it! I said, ahh! That's how you help yourself [encouraging other midwives]. Yes, it's helping me, yes, because the exercises I do, it makes my body flexible and then I hardly complain of backache because of the kind of exercises I do. So, I feel that one [exercise] has been helping me to cope! Probably they [other midwives] are not engaged in any little exercise. But again, with the backache, they might need to. I hardly develop backache; that is why they see me working round the clock and very fit to cope with the work (Anna, Interview, Hospital B).

Some midwives reported using medication for pain relief (analgesics) to relieve body pain, this enabled them to continue with their work the following day. Linda commented that she relied on analgesics to function in her job each day:

You take analgesics so that you can perform well the next day (Linda, Interview, Hospital A).

Deborah also reported using ointment on her legs to reduce the pain, she believed this was due to standing for long hours. She added that she also took pain killers sometimes to get relief:

Sometimes I take analgesics. Paracetamol. Not often anyway. Sometimes I rub an ointment on the legs, and you see that am strong the next day (Deborah, Interview, Hospital A).

However, some of the participants discussed taking analgesics only after a difficult shift. They reported that due to pain, fatigue, and exhaustion from the heavy workload and bad posture at work, they are forced to take analgesics to relieve the pain. In Anna's interview, she admitted taking pain medication, especially after a difficult shift, when she feels tired and exhausted:

After a difficult shift, we normally go home, very tired and exhausted, so we normally, we take analgesic always after a difficult shift, you see that we become better to go to work the next day (Anna, Interview, hospital B).

8.3.9. Having a professional detachment

The experience of witnessing a traumatic birth was a common occurrence for many of the participants. This was not surprising given the high maternal and infant mortality statistics for the country. Frequently the participants reported the importance of a detachment as a professional necessity to enable them to carry out their responsibilities. They reported that having too much empathy following a traumatic birth brings about a low mood and prevented them from carrying out the task ahead. Ladidi, recounted her experiences following a traumatic experience as described in the data extract below:

I always put the loss of life aside, though I feel pained after a loss. But move on afterward. I can't bring life to that child. After counselling [the mother], I always put issues of such [any loss of life] behind me and forge ahead with my activities, so I only pray that at the end that God should give the person the grace to bear it and God should give the person the next one to be a live baby. Once I do that, I get relieved, and I forge ahead, and I will only pray and encourage her, so I get much relieved (Ladidi, Interview, Hospital A).

Maimuna recalled her experience after witnessing a traumatic birth, she described how she managed during this period. She took a break from the unit so that she could put the

neonatal death behind her, this enabled her to cope with the stress and the resulting negative emotions:

I remembered an experience after a mother lost her baby after fifteen years of trying to conceive. I felt so bad for this patient. I left the ward immediately after the family took the corpse away. I went to a quiet room and took a break from the ward so I can put myself together. As a midwife and from my experience, one must move on because you have many women there to attend to. After discussing it with the woman about the cause of death, I felt better. I tried to take my mind from it and take my mind from that experience. When I participate further in the birthing of a healthy and live baby, I feel better (Maimuna, Interview Hospital B).

Several participants highlighted detachment or distancing from the event to help them manage their emotions while at work.

8.3.10. Having a sense of purpose and professional Identity

Participants emphasised the importance of having a strong sense of personal and professional identity. They talked about the importance of having the passion and the love for midwifery practice. Also, the participants mentioned the importance of having a sense of belonging to a professional 'family' as a necessity for surviving workplace adversity. The participants described midwifery as a calling, a sense of vocation rather than what they do for a living. That is, professional identity was merged with personal identity. Many participants viewed their profession as being a core part of themselves. This theme has some overlaps with spirituality.

Josephine reported that having a passion for midwifery was an important tool for coping with job stress. She added that with passion for midwifery, a midwife could withstand difficulty or challenges at the workplace:

They need to have passion, that passion for serving their patient because if you don't have that passion that is where you will start having problems or clashes with your work when you have that passion you have your patient at your heart, you can deal with anything that comes up, so they have to be very, very patient (...) and then will be able to cope with the stress [Josephine, Interview, Hospital A].

Participants also emphasised a range of specific personal attributes that they felt contributed to their ability to cope in times of workplace adversity. These included self-confidence, competency with midwifery skills, interest, and self-awareness. Josephine emphasised that having the requisite competency skills, which she described as coming from experience, enhances resiliency because these skills provide direction on what to do

when a difficult situation arises, preventing confusion, and enabling midwives to 'act effortlessly':

You also have to be competent with midwifery skills. You know when you don't know what you are supposed to do at some point, it can make you confused; it can even make you tired. Yes, but when you know what to do at each point, I think you could easily act effortlessly. But where you are confused, you don't know what to do. You get more worked up and tired (Josephine, Interview, hospital B).

Similarly, Mariya emphasised that being competent enhanced one's confidence and the ability to cope with workplace adversity; she explained that being confident during difficult times is a necessity for developing resilience. This can be seen in the data extract below:

You know you will have to be confident in what you are doing ok, this usually comes with if one is competent as a midwife, when you have confidence in what you are doing you will be able to deliver, but when you don't have confidence, you will be doing this and that you know, and maybe exhausted at the end of the day. But if you are confident, you will be relaxed while doing your job (Mariya, Interview hospital, B).

Most of the resilient midwives also emphasised the importance of having a professional interest, they felt this was a necessity for coping with workplace adversity. Bianca recalled that without professional interest she would have been unable to deal with the work pressures in midwifery, she would have requested a move to another unit where she believed she would be able to cope better:

Halima: Do you consider yourself as coping?

Bianca: Hmm, I feel I've been coping. I've been coping; if I've not been coping, maybe I would've requested to go to another unit [laughs], because I am interested in midwifery. It is purely the interest! The interest, you know if you are not interested in a particular place before challenges even come, you have already opted out. But if you are interested in a particular place, you must have checked, imagined the challenges you are going to have along the line, you now advise yourself, 'will I be able to cope?'. 'Will I be able to cope if this one will come up, what will I do if this one comes up?', but because of that interest you have you feel happy, you want to be a fulfilled midwife if you keep on pushing (coping with stress), the most important thing is the interest (Bianca, Interview, Hospital).

The participants unanimously emphasised their love for the job, particularly 'love for midwifery'. They all agreed that they loved the work they were doing, reporting that though the work appeared challenging it was also interesting and rewarding. They also believed that they were useful in assisting women in their most difficult period. Participants

contended that the love of this job served as a buffer for stress and enabled them to cope with the challenging nature of midwifery.

Jummai explained that she saw midwifery as dealing with two lives and as a calling to serve humanity. In her experience, this belief helps to create a sense of coping with the challenging nature of the work, this can be seen in the interview excerpt below:

We encourage ourselves [laughs] we encourage ourselves now, but the most important thing here is we do it; happily, that's how we do to cope with whatever we are doing. We have signed for this work, and this work is a call from God to serve humanity. This is because only a few are called to this profession. We are dealing with two lives; we are not dealing with books. So, we have to, we have to work very hard to save lives, we have to do it with joy, so that we perform it effectively and because I encourage myself, I cope very well. Because I don't break down because it is something that I like (Jummai, Interview, Hospital A).

8.3.11. Knowing oneself.

Some participants emphasised the need for developing self-awareness, they felt it was necessary for coping with workplace stress. They recounted the need to know oneself and having a good temperament as very important in the building of rapport and gaining patient trust during care. Mariya described how developing self-awareness at work was necessary for midwives. She remarked on the importance of knowing oneself and adopting more positive behaviour to promote a better working relationship with the women. She suggested that it was useful in gaining cooperation from the women, thereby reducing pressure when providing care to them:

But the truth is I know myself, ok, I know myself, you know in the first interview, I told you I used to be highly temperamental, and I told myself! Look, this is one of your attitudes and is not good for you as a health worker. If you want to achieve something, you have to work for it, and you have to give your client's confidence. Like I have said, I have worked for over fifteen years in the labour ward, ok. I now found out women need somebody they can confide in, someone they can trust. I said to myself, Mariya! You must work on your temper, so when you get irritated easily, they can't confide in you, and you will not get results. I started telling myself that it is not everything that should get you irritated; push some issues aside as if you didn't see them. And sometimes, when I feel I want to get angry, you know I used to take deep breaths and continue with my work. So even with clients too, when you feel you want to get angry, you tell them no, this is what you are supposed to do, by so doing, you find yourself easing the pain and let it go. So gradually, before you know it, you find yourself coping. You find yourself working on your attitude. You need to tell yourself that this thing is wrong, but

when you don't accept it, you cannot work on it (Mariya, Interview, Hospital B).

The above data extract provides an account of developing self-awareness and 'working on the self' in order to do the job effectively and 'get the result'. It also describes the importance of controlling what you can and accepting what you cannot control for the purpose of developing resilience at the workplace.

Mary also reported the importance of 'working on self' in order to develop tolerance while dealing with the women at such a difficult time. She described this act as very useful for gaining cooperation and building rapport with the women, this reduced tension when providing care.

And again, a midwife needs to work on herself because you know I cannot tell myself lie, I know myself, I cannot tell myself lie about myself because I know myself. I use to be someone who easily gets irritated, and I had to tell myself, I need to work on my attitude because I work with women, and of course, sometimes they exhibit some characters that may not be palatable to me, I need to be patient, I need to go on. So my attitude towards work should also change as a midwife, ok, I think with that I was able to relate well with these women and also gain their cooperation when am giving the care (Mary, Interview Hospital A)

8.3.12. Preparing mothers on what to expect of 'labour and birth'

The midwives also mentioned the importance of preparing women on what to expect of labour and birth. This was beneficial not only for the women but for the midwives too. Most participants felt that the difficult and challenging behaviour of the women was due to poor understanding of what to expect during labour. They reported that due to a shortage of staff, some midwives might not have been able to pass information to the mothers, as a result some mothers did not know what was expected from them. The lack of knowledge, putting all responsibility on women combined with low health literacy, might lead to fear, panic, and mistrust. This in turn could lead to difficult interaction with the patient, her relations, and the midwives. Joan recounted describing the intensity of labour pains to the women, this helped to prepare them for labour with a key aim of making the midwives' work easier:

Hmm, I used to prepare all the women towards the last month of their pregnancy what they need to know when they come in labour. We don't have anything to give them as pain reliever here and other hospitals, oh, in this part of Africa, we don't have anything to give them, and they just have to endure it. That is why sometimes during ANC [Antenatal care] we use to tell them, those that are first timers, the primies, [pregnant for

the first time] if anybody should tell you that labour pains are not severe is not true! I am telling you, even when they come for the first time, I tell them labour is painful. And as you are progressing in labour the pain is increasing, so you just have to be prepared and endure it, don't shout, don't do this, don't misbehave 'Jokingly,' and they laugh about it. I say, 'it is painful oh' and as it is progressing, the pain is increasing, stronger and stronger, so I say just be prepared, accept it the way it comes. I even tell them the duration of the labour. I prepare them well; they know me well. Because we don't have any pain reliever here, pain killer NO! This usually helps me prepare their minds, and so they cooperate with whatever I ask them to do while experiencing the pain. So that will make your work easier for you when they cooperate and then less the stress for you (Joan, Interview, Hospital B).

Similarly, Jodie mentioned the importance of preparing women, describing what they might experience during labour and birth, especially during pregnancy. She saw this as beneficial for the women and felt that it would encourage women to cooperate with the midwives when they arrived at the labour ward for birth, thus ensuring a positive experience for both the mother and the midwife:

One thing I want to say is that due to a shortage of midwives, we don't have time to give all the information to the mothers when they come for booking. You can imagine six midwives seeing two hundred and sixty women for booking. You can't say everything. I used to tell the women what they need to know when I am giving health talk to them at the antenatal clinic. I educate them on labour ward and how they need to cooperate with the midwife and the doctors and what they should do. I used to encourage those mothers who can also read to read more on the internet, especially mothers approaching term [end of pregnancy]. This usually helps these midwives also and also helps me a lot when they come in labour that is why I was posted back to the labour ward to work. I take my time to talk to these patients. I tell them the financial implications and the hospital routine requirement when she comes to deliver in labour. I keep reminding them to buy things needed at every ANC visit. I don't get tired. I just love it, and the patients love me a lot as I tell them to scream if they like. It will be over, and they love me so much and am so happy about it. And when the baby is born, we [midwives and the mother] become all happy (Jodie, Interview, Hospital B).

8.3.13. Building interpersonal relationships

Most of the participants emphasised the necessity of building interpersonal relationships by using good interpersonal communication skills when interacting with other midwives and women. Interpersonal communication equips midwives to cope with the increasing demands and stress of midwifery, it enables them to advocate for themselves and others

skilfully and productively. Participants identified that having good interpersonal communication skills was very important in navigating the complexity of their day-to-day tasks. These skills included active listening to the woman's wishes, being patient while listening, and showing compassion when dealing with the women. This focused code was developed because there were many instances when midwives talked about the importance of building an interpersonal relationship with the client, their relatives, and the various ways it could be achieved. Poor interpersonal relationships were a major cause of workplace adversity resulting in poor client - midwife interaction. This eventually created more stress for the midwife, together with other stressors at work. Poor interpersonal relationships were considered a cause of adversity, developing good relationships was a resilient response to this. Often, the resilient midwives emphasised the value of interpersonal communication skills, they felt that they were equally as important as having good clinical skills for surviving and thriving in the face of workplace challenges.

Mariyah identified the importance of using good interpersonal communication skills, including listening skills, particularly with difficult patients. She reported this as important in achieving a positive client-patient interaction, hence reducing stress on the midwife:

I think communication should be in such a way when I say IPC; I mean interpersonal communication skills; if you can be able to speak well and listen very actively to those people (women or their relations) when they want your attention, no matter how crazy the person is. We have tried patients or relations that are like that when they are very aggressive, and you call on them, you sit them down, you get a place, just to sit down and talk to the person. Truly, I believe that that person will know, except if that person is mad. Somebody (a midwife) that will explain a particular thing, and you [the midwife] calm down to explain to the person, the person will get your message. So, I don't have to be tough with them, if I get tough the way they are tough, it will not work (Mariya, Interview, Hospital A).

The participants also emphasised the importance of being patient with the mothers and their families. They recounted the importance of explaining expectations to the patients and their relatives, this helped to foster a trusting relationship and to prevent poor communication that may result in workplace violence. Hajara described the importance of being patient with the mothers and their relatives, this helped to gain their confidence and fostered a trusting relationship. This she believed could help prevent aggression towards the staff at the workplace:

Sometimes you can have a patient relative wanting to hit you as a caregiver, so you have to be patient, make them understand because by the time they bring in their patient, both the patient and the relative are

always anxious, so you have to take your time tell them what to expect and calm them, try to win their confidence so that they will believe that since they are with their relatives, you are capable of giving or caring for the patient till she delivers. So, you have to be very, very compassionate, political and patience in dealing with them (Hajara, Interview, Hospital B).

Jodie pointed out the importance of being empathetic with the women to understand what they are going through, this helped her provide care for women whom she found more difficult to relate. She talked about communicating to patients sensitively using the appropriate body language and the importance of tolerance:

Actually you are in the job, you find out that there are some patients that you cannot tolerate, but yet, knowing who you are (midwife) and why you are there, you have to accommodate them and understand with them that they came there for a purpose, and you are also there for a purpose putting yourself in their shoes, there are times that you have to put yourself in their shoes, so it all matters on your IPC, that is your Interpersonal communication. You have to know how to get to them, and so when you can properly communicate to them, your nonverbal and verbal communication is there, you know it helps a lot and creates understanding and cooperation (Jodie, Interview, Hospital B).

Participants also described how midwives benefit from caring for more receptive women. Deborah described interacting with cooperative patients as important for promoting coping for the midwives. Using good communication skills in supporting women in labour facilitated their cooperation:

The easy to control patients when they come, and you tell them what to do carefully in a good voice, they give you full cooperation, and at the end of it, you deliver their babies, which gives you more kind of motivation to keep on going. So, the women, too, the clients, still have a positive impact on us working for them for providing the total care they need (Deborah, Interview Hospital A).

Although the above data extract shows that this midwife is describing a positive attitude towards the women, there is also evidence of a controlling approach in dealing with women's birth experiences to promote coping. This action invariably shows some degree of disrespect to the women considering the way and manner they are being cared for when linked to the various forms of disrespect as described by the World Health Organization (WHO, 2015). The behaviour of these midwives and the link to disrespectful care is discussed in the subsequent chapter.

Most of the resilient midwives also remarked on the importance of using good interpersonal communication skills when interacting with other midwives, they felt this was

useful in creating a sense of coping with stress. They also recognised that most midwives may at times be impacted by stress from the system, so they learned to support one another. In Joan's interview, she indicated the importance of using good interpersonal communication skills with a colleague as being useful in promoting teamwork and thus promoting coping. She recognised the importance of knowing that most midwives' actions and inactions were a result of the stress impacting on them from the system they work in and the reason for some of their actions. This is seen in the data extract below:

I have to work with them for the patient to get the best. It is only to work for eight hours, and you are gone, you are not going to be there for 24hours. So, you do your best within those eight hours by communicating with them appropriately using the interpersonal communication skill because we understand that sometimes they (colleagues) are impacted by the stress and the whole system (hospital) they are working in, and negative or let me say poor interactions with colleagues are not necessarily due to the midwife's actions (Joan, Interview Hospital A).

The above issues or processes are interlinked and are useful in the process of developing resilience. For example, the use of improvisation and becoming super midwives are all pragmatic ways of dealing with human and material resources. Also having a sense of spirituality, a sense of vocation and calling and a sense of purpose are interconnected and are all useful in the process of developing resilience. Spirituality influenced their thinking through trusting in God's providence, especially following a traumatic birth experience, and seeking help from God for strength to help navigate through their difficult workplace. Having a sense of calling is linked to a sense of purpose as these keep the participants reenergised and motivated because they are working within their calling and their purpose. Chapter Ten provides the theoretical model of the way in which the participants draw from these strategies.

8.4. Conclusion

This chapter explored the understanding of resilience and the resilient strategies the midwives adopted in the face of workplace adversity. The findings from the midwives' perspectives specifically addressed the contexts, understanding of resilience, and the various strategies used for developing resilience. At the beginning of the data collection, the word 'resilience' appeared vague and poorly understood by some of the midwives until it was termed 'coping'. The midwives engaged in active meaning-making to make sense of resilience and their understanding of the construct. They described coping as maintaining performance despite the difficulty, not breaking down, coping as a result of

experience. The midwives drew on a number of coping skills or resilient strategies to move past the adversity they experienced. This chapter has described the thirteen focused codes which illustrated some of the proactive and pragmatic ways the midwives dealt with events in their day-to-day life. The next chapter presents the fourth and final category.

CHAPTER NINE - The impact of the institutional environment

9.1. Introduction

This chapter presents the fourth and final category. This category describes the impact of the institutional environment and how it can contribute to adversity but also to resilience. This category includes descriptions of how workload was a source of adversity to the midwives. The participants emphasised the need for more midwives to be recruited to the hospital. They further explained the need for midwives to be rotated from units with busy workloads to ones with lighter workloads and vice versa. They further noted that the staff ratio in such busy units should be increased, this would improve their ability to cope and strengthen resilience. The participants reported how an increase in salary helped to strengthen their resilience and also boosted their morale. They also declared that remuneration should be increased, this would improve motivation and act as a means of strengthening their resilience.

This category also included participants' stories of the importance of training for managing workplace stress and promoting resilience in midwives. They further provided information on how training on some aspects of clinical skills had improved their confidence. Furthermore, they emphasised the need for such training, they felt it would help to strengthen their resilience. They also remarked on the importance of being supported by the institution in order to improve their clinical knowledge through further education and continuing professional development in midwifery.

The participants also spoke of a lack of basic resources in the labour ward such as the appropriate birthing beds, and other consumables, this created difficulties for them. They emphasised the need to provide such resources to enhance their resilience.

The participants further declared that a lack of guidelines for managing normal births and complications created a sense of adversity for the midwives. They emphasised the need for institutions to provide guidelines for managing normal births as well as for the management of common complications such as postpartum haemorrhage and eclampsia. It was believed that such guidelines would ease their work and thus enhance resilience.

For this category five focused codes were developed, these include: managing human resources, increasing remuneration and recognising midwives, education around managing personal stress and updating clinical skills, providing material resources for

managing births and developing guidelines for managing births. These codes are described in the following paragraphs.

9.2. Managing human resources

Most of the midwives reported the need to curb workplace adversity, emanating from heavy workload, through the recruitment of more midwives. Several participants also emphasised the need to rotate midwives from one unit to another after a specific period. They considered this possible because midwives in Nigeria are double qualified and this enables them to function both as a general nurse and a midwife. They reported that the rotation of midwives had the potential to strengthen coping mechanisms. Many of the participants felt that midwives would be able to cope better if they were rotated from a busier unit to a less busy one and vice versa. Some participants also felt that midwives should be mobilised from within the hospital's unit, where workload for the midwives is manageable, to the labour ward where workloads are often overwhelming. This would help to reduce midwives' workloads in such units.

In the data extract below, Deborah justifies the need for institutions to employ more midwives to work in labour wards. She reported that recruiting more midwives may reduce the burden of high workload on the front-line midwives and compared this with the advantages of higher staffing levels in accident and emergency wards.

I am coping well. But to make things easier for us, the management should employ more trained midwives; they should select the best from those students graduating from the school of midwifery to join us in labour ward. It is not easy; they should employ more trained nurses. By the time we are seven in a ward like what they did in accident and emergency, by the time we are up to eight, seven in each section, we were more than sixty midwives sometimes in accident and emergency when I was working there. It was so easy because of the number of staff. We were able to take care of the patients there. If they can employ more midwives in the labour ward, things will be easier, and the kind of quality we give to the women will improve very well and even at night shift too we would have more midwives to take care of women in labour (Deborah, Interview, Hospital A).

Aisha emphasised the benefits of rotating midwives across all the units. She argued that if the midwives are moved from the labour room to other less busy areas and replaced with a new set of midwives from other units, it might reduce stress on the midwives and create a sense of coping. This is reflected in the data extract below:

They should not keep some midwives to stay too long in the labour ward. There should be a rotation so that when you work there for

sometimes, you should be transferred to a less busy area so that some other new set of people [midwives from other units] can come too and work there. So that you [the midwife] will not be there for too long, and then you will be stressed at the end of the day (Aisha, Interview, Hospital B).

Bianca felt that management should move staff from a quieter area to a busy area as needed. She too argued that the management should identify areas of high workload such as labour wards and mobilise midwives from other units with smaller workloads to help manage the workload in busy units. She described this as useful for strengthening a sense of coping and reducing burnout among midwives:

The human resources, they [the hospital management] should understand the areas that need many nurses more than the other areas. Some areas are very stressful than others; you [the hospital management] should put in more nurses so that they will be able to cope; they will be able to adjust. The burnout syndrome will be reduced among them. Those that already have backache would have time to attend to themselves or see a physiotherapist or any relieving system they want to do. They would also be able to create time for a break so that the midwives can rest while they are still working. When you go to the clinics and out-patients' clinics, you will find lots of nurses[midwives] while in the labour ward they are looking for people [midwives] to give them a hand and they are not enough to support (Bianca, Interview, Hospital A).

Many of the participants considered taking a break as a necessity and a means of reducing stress, particularly when the work is emotionally demanding. They stated that taking a break also provided an opportunity to network and socialize with other midwives and rest the mind as well as the body, thereby strengthening coping. They emphasised that the management of the various hospitals should enact a strong policy regarding break time, making it mandatory for all midwives and providing an adequately furnished room in the unit where midwives could go for a break and debrief with other colleagues.

This is because, due to the blurring of time as a result of workload, lack of a good space for leisure and break, some midwives forget to have a break because they are engrossed in their work, creating a sense of adversity for the midwives. Binta suggested that if hospital management made break time mandatory and provided comfortable, safe rest areas, staff would be able to take a quality break, have time to interact with other colleagues regarding workplace issues and thus reduce stress:

If they have enough staff, the management can make break time mandatory. You must go and rest. And you get somewhere that is very conducive where they can have that rest (...) get a place that is safe that

people can go and stretch out at a particular time. In some areas, they could even provide them with something or even snacks for the midwives. So, they can stay in their conference or common room and take something before they continue their work. it would also provide a space to discuss with some of their colleagues about some issues bothering them. It will help a lot and reduce stress on them[midwives] (Binta, Interview, Hospital A).

Mary considered that the need to provide a healthy and suitable rest facility was equally as important as having a break. She reported the absence of a good rest facility as a source of stress for the midwives. She emphasised the need for the management to provide a quality restroom for staff wellbeing and to strengthen and foster resilience and make the midwives feel valued and respected:

We don't even have facilities for resting. I think going on break is equally important as having a suitable place or a common room where we can rest. We don't have such here. We have a very small space where we go for a break. There is no ventilation there, no good sofa to even relax. Sometimes there is no space even to sit down, and we call there a restroom! The management should do something about it. They should get a better rest facility for us that is adequately furnished, good toilet facilities and very nice sofas where we can sit and relax, items for tea or coffee and other stuff. I don't think I am asking for too much because we spent most of our time at work, so we need a quiet and good place to take our one-hour break before returning to the ward. Even a quiet place where we could say our prayers. That will help us a lot and make us feel respected and also help us to cope more too (Mary, Interview, Hospital A).

Jodie also expressed the importance for ward managers to ensure all staff take a rest break to prevent fatigue-related incidents and thereby improve the safety of the patient. She reported that because of the high workload and the passion for midwifery, sometimes midwives refused to take a rest break. She felt that managers should insist on this as a means of strengthening coping and reducing stress on the frontline midwives.

I think all ward managers should also ensure that every nurse had taken her break even if it's for a few minutes. As the ward manager here, I ensure that all the midwife under my care go on break for us to be able to cope with stress while we are working because I don't want anyone to collapse while working, I have had so many experiences where a midwife collapse while working due to fatigue and lack of rest break. I used to tell them to go on break! There should be somebody to relieve you. I check all my staff and ensure they have all had a break. It is a must! Take that little time off. It matters; by the time you come back in, you are refreshed. It is not a do or die affair that you have to be there. Some of them[midwives] will say Ahh! This work is too much! There is

no way I can go on break now. I will say 'No No, No No No!' I always insist. You won't be able to put in your best. But by the time you take time off. You're refreshed you've taken something even physically you have sat down and taken some rest. So that relaxation, that break time, is necessary. It is helping us to reduce stress, that's how we cope with the stress, getting on break at our time (Jodie, Interview, Hospital B).

9.3. Increasing remuneration and recognising the midwives

Most of the midwives considered that they should be paid more than nurses because of the complex nature of midwifery. Nafisa contended that the midwives' salary should be improved proportionately to the difficulties involved in the care of the women, considering the fact that the midwives are dealing with the safety of two lives. This is illustrated in the data extract below:

So there should be more incentives [salary] in most of the facilities, given the recognition that a midwife is one that assists in bringing life; that is new-born coming into the world, gets into her hand,(...) she is the one involved in bringing that one [a baby] into the world, so she should be given consideration as she supports two lives and not one like other nurses who are dealing with only one patient alone. Hence incentives should be increased. They should be given something added to their normal salary so that it will give them a reason to buckle up [strength for the job] and bounce back and do their job (Nafisa, interview, Hospital B).

In a fieldnote extract from a discussion with Fatima, she identified the increased risk of bloodborne infection that midwives are exposed to because of the nature of the job (e.g. Hepatitis B and HIV). The risk was felt to be higher than that experienced by general nurses and therefore midwives should be compensated for this, it also justified the need for a salary increase. She thought this would help to promote a sense of coping for the midwives:

She stated that because midwifery is quite stressful and needs a lot of work and commitment, midwives should be well paid compared to other general nurses. She also added that because it involves dealing with blood and, it is a kind of dirty job, where you have to deal with blood and blood product almost all the time together with risk for infection, midwives should be highly paid than other nurses. If they considered that, all midwives will be motivated and will be more than happier and will be able to cope better (Fatima, Fieldnote, Hospital A).

Most of the midwives remarked on the importance of the organisation recognising their efforts. Bianca emphasised the need for management to recognise and value the work of the midwife, for example, by visiting the labour room to observe the conditions and to commend midwives for their work. She contended that because the act of midwifery is

considered to be 'priceless', they should be well recognised and valued by the senior hospital colleagues and management staff of the hospital. This recognition was considered very important for strengthening resilience amongst the midwives and increasing motivation:

Because most often you cannot pay the midwife for what she does [midwifery as priceless] they should be recognised in everywhere, in every aspect of the work they are doing, because, they are taking care of two lives, both the mother and the baby. The management should kind of periodically gather them [midwives] recognise what they do in the hospital, like maybe just coming to us and say well done, you've done a good job, well-done.!. We will be motivated (...) the hospital management needs to come and peep [view] and see what we are doing. Yes and when we see them coming into the delivery suite, we will be motivated, and they have to show concern for us, that is why they are even here, not to come and supervise us but when we see them always, we say Aaah, they are aware of us, they are concern about us, look at them coming to see us, caring for this plenty patient and when they even say thank you, well done! and just move on. We will be happy! [emphasis] (Bianca, Interview, Hospital B).

Most participants suggested that the efforts of the midwives should be recognised to encourage and create a sense of coping with workplace stress. They contended that hardworking midwives should be encouraged more frequently with a reward, this would boost their morale and stimulate coping. Mary reported how motivated she felt when she received an award for excellence for her hard work and contribution to maternity care in the unit. She stated that such action further encouraged other midwives and served as a means of strengthening coping among the midwives in the units:

I want to say if the management can even introduce cash or gift also to us especially very hardworking midwife at the end of the year, it will encourage us more, for example, four years ago I was given an award of recognition for contributing to excellence in maternity care and a little token to go home with. That really motivated me, and I also wanted to give in my best. You do more when you are being valued. Other midwives, too, became so happy because they know me well, and they felt I deserve the award. So even most of them became more motivated and even happier. If the management can continue with that, I believe it will encourage us more to do more .it will make us cope well and boost our morale (Mary, Interview, Hospital B).

9.4. Education around managing personnel stress and updating clinical skills

Most of the participants emphasised the importance of training and retraining midwives, they saw this as necessary for promoting and sustaining resilience amongst them. In particular, they reported the need to address the issue of managing stress through training on various coping mechanisms available for midwives. Some of the participants talked about how previous training on certain areas had improved their competence and confidence. Mary justified the need for an update on managing stress, she felt this would be useful in promoting the intention to stay in the labour ward:

It will be very good if they can organise training concerning coping with stress for midwives. It will encourage us to know how to cope more, some people, because of the stress they encounter in the labour ward. It makes them go and request to be moved out of the labour ward to other places. So, if there is a way they can do any training, organise any training concerning coping with stress, it will help some of us. [the midwives] to remain there [labour ward] (Mary, Interview, Hospital B).

Participants also reported that routine updates on the midwife's knowledge, especially in areas where knowledge is lacking, would boost their confidence and enhance their competency in dealing with certain clinical conditions when they arise.

Hajara expressed a desire to receive specific training in areas of need so that midwives could enhance their knowledge and ability to cope. She suggested that management facilitate training on the resuscitation of the new-borns for the midwives in the labour room, this would help improve their skills and confidence and strengthen coping:

There was a time the hospital organise a training for us on management of PPH [post-partum haemorrhage] after the training we were all confident to care if we have a woman with PPH, we know the signs and what we can do because it is the cause of death in this area .I want training that has to do with the resuscitation of the baby, but since I have started here, [working in the current hospital], There has been nothing like that (...)we in labour ward we are the one that receives the baby before the baby gets to SCBU [special care baby unit], we are the ones that have the direct impact, we touch the baby first, and we should be able to give some resuscitation, if a baby comes out with asphyxia, we should be able to give the little we can before we move the baby to SCBU so if there is a way they can organise workshop or training for midwives in labour ward, concerning maybe resuscitation of baby, APGAR scoring, and things like that. It will enhance our productivity and reduce our stress on us because you know what to do at a particular time (Hajara, Interview, Hospital B).

Deborah expressed concern about the need for training and retraining of older midwives to update them on current trends in midwifery practice, this would enhance coping. Considering the significant amount of time that had passed since their original training, providing updates to enhance their knowledge base and improve their skills would be beneficial. This is illustrated in the data extract below:

Organising updates on training for the older midwives. Because as I told you, new trends are coming up in midwifery. Sometimes, you find out that most midwives are midwives for twenty, fifteen, ten years, so you cannot compare them with a new midwife who has just qualified (...) you know those midwives that have been working are more experienced than those that are just coming in. Those that are coming in are more knowledgeable than the ones that have been there for twenty years. So, organising those training will improve their knowledge. Their knowledge will be upgraded to the latest trends in midwifery; that is what I mean by training and retraining of the old midwives. It will update their knowledge and skill in providing care and will reduce too much stress on them (Deborah, Interview, Hospital B).

9.5. Providing material resources for managing births

There was a major emphasis on the need for healthcare facility managers to provide the delivery suite with all the necessary materials (consumables, instruments, and basic equipment) for managing labour and birth. Participants reported this as critical for promoting and sustaining the ability to cope with adversity. In Anna's interview, she reported the need to provide the labour ward with adequate delivery items ranging from surgical gloves to other consumables to reduce stress on the midwives. She reported that this was necessary because some women arrived without any birth items for use whilst in labour, thereby creating difficulty for the midwives:

Yeah! You know there is a lot of difference when you want to work, and you have every instrument ready for the work; I mean instruments for taking deliveries. Most women will come, some of them come without anything [childbirth items]. But if these things are available; you need to do vaginal examinations, surgical gloves are there, even if ten women are delivering you need to have ten packs available as well as other consumables like the syringes, pads many other items for delivery. It will make the work easier and less stressful for us when all these are provided to us by the hospital (Anna Interview, Hospital A).

Binta was particularly critical of the failure to provide the labour ward with the appropriate birthing bed to promote good ergonomics. In addition, she emphasised the importance of providing resources for managing births so that midwives did not waste time and energy trying to find equipment. This was typical of many:

To prevent pains in the body (backache and body pains) the management should get the normal delivery beds; so when you are conducting delivery, you take delivery standing, your spine will remain on the normal position (...), so the midwives will not have challenges with their health. If they can get the ideal delivery bed, get the instrument, get the normal equipment because there are times, like you want to take the blood pressure of a patient, and you cannot get a good sphygmomanometer, you have to run around to get it. The energy that you have used to go and get another spyg, if you convert it to something else, you will have achieved more if that spyg is besides that patient and you did not go extra mile to go and look for it. Also, to suction a baby, maybe there is no light (electricity), you cannot make use of your suction machine. You start looking for a manual suction instrument, and we all know that if you should use the electronic one, it will be faster and easier for you, and you get a better result. But here, you have to start running up and down to make do with whatever you can get. So, if the institution can get all these things ready, the energy we burn in getting all these things will be reduced, and you now direct the remaining one[energy] in caring for the patient; you will not be able to break down on time (Binta, Interview, Hospital A).

9.6. Providing evidenced-based protocols and guidelines for managing birth and common complications

Most of the participants expressed concern about the absence of an evidence base guideline or a protocol for supporting women in labour and women with common complications in labour. Such guidelines have the potential to guide the actions of the midwives during the care of women in labour, thereby reducing stress and strengthening coping. They also reported that these guidelines were very important, especially when the labour ward was busy with women experiencing some of the common complications such as postpartum haemorrhage and pre-eclampsia in pregnancy. Complications such as these require obstetric input from medical colleagues who were often not readily available, this meant that midwives had to contact them before appropriate care could commence. In these instances, guidelines may assist midwives to commence management of the condition whilst waiting for the obstetrician to attend. The participants also considered protocols to be useful, they enable the midwives to provide uniform care during labour management and also promote the provision of respectful care to mothers. Nafisa emphasised the need to develop a protocol for management of women in labour based on best practices. She considered this necessary due to differences in the pattern of care among the midwives, this was considered a source of stress for the midwives. She pointed out that developing a protocol based on best practice and evidence will guide the midwives during the provision of care and will help to create a sense of coping:

I would also say that, if there can be a guideline, like let me say a protocol showing a straightforward plan base on best practices for the midwives to follow when caring for a woman when she comes for delivery and what cervical dilation should they commence some actions, even if we know it as midwives. I mean, just action by action plan throughout, concerning the care we give to this woman until she gives birth and even discharge. It will help us a lot and will guide us on what we should do at all times. Some midwives have a different approach; some will not give water or anything when the women are in labour, while some will or will send the woman away when she is not in the active phase while some don't. So this confuses us. Sometimes when we try to explain to some of these women, they get angry at us because you try to do the right thing while some will not especially when there is a crowd or at the period of the year when delivery is at its peak. In short, just a protocol for birth in the labour ward for midwives and should be displayed in the ward for the midwives to see, and the ward manager must make sure all midwives follow the plan very well. I think it will reduce the stress on us (Nafisa, Interview, Hospital B).

Jodie also reiterated the importance of providing a protocol for managing complications like postpartum haemorrhage. It was felt that a protocol would enable midwives to deal with an emergency during the event, the guidelines could be used before the arrival of the resident doctors, and this would create a sense of coping:

The management of the hospital should liaise with the doctors and senior midwives to kind of bring or design a guide or guideline base on best practice on how to manage a postpartum haemorrhage and eclampsia because such complications are very common here, sometimes these women are brought in fitting or paperwhite (from anaemia), we have to look for the obstetrician on call. Meanwhile, we are just two midwives on a night shift. This guideline will be very good for us. I know what I am talking about it has happened to me many times. It's a lot of stress. If the guideline is developed and kept in the labour ward, it will help us a lot to cope and act when this kind of complication happens (Jodie, Interview, Hospital B).

The above data extract shows the importance of developing a guideline to reduce stress and promote coping among the midwives. Because the doctors were not always around, the midwives became responsible for contacting them in order to deal with some obstetric emergencies. Therefore, providing the labour ward with such a guideline would help to promote coping with work stress when a situation arises.

9.7. Summary

This fourth and final category is about the institutional factors that impact on the development of resilience rather than on what needs to change (the two are linked but the

emphasis is on the impact of the institutional environment). As the midwives described the environmental challenges they experienced, they also suggested what changes should be made. These will be discussed again in Chapter Twelve. The next chapter builds on the findings from Chapters Seven, Eight and Nine and presents the interpretive and theoretical renderings that gave rise to a middle range theory of midwives' resilience.

CHAPTER TEN - Finding Perspective: A Midwives' theory on Workplace Adversity and Resilience

10.1. Introduction

This chapter presents the interpretation and theoretical renderings of the previous sections' findings, specifically on the way midwives find perspective by developing resiliency in the face of adversity. A middle-range theory of workplace adversity and resilience was developed, which is presented in this chapter. This chapter begins with a general discussion of what a theory is, the different levels, and the types of theories that exist. It further considers how theories are developed and how they inform midwifery practice. It also describes the generated theory and the related concepts.

10.2. Definition of a Theory

The development of theories relating to a profession provides a “logical, systematic and organised version of that profession and its aims” (Peter et al., 2020. p.2). It is essential to understand what theories are and how they are applied in the context of midwifery. A theory is defined as an “internally consistent group of relational statements [about concepts] (...) that presents a systematic view about a phenomenon, and that is useful for description, explanation, prediction and control” (Walker and Avant, 1988, p.22). A theory can be viewed as “a creative and rigorous structuring of ideas that projects a tentative, purposeful and systematic view of phenomena” (George, 2011, p.34). As such, authors like Bryar and Sinclair (2011) propose that theories are made up of concepts and prepositions that explain relationships between the concepts. Bryar (1995) opined that theories can be presented in a visual format or as a diagram of the theory's content. Looking at the functions of theory, Fawcett (2005) noted that theories are developed to explain a particular phenomenon within a conceptual model and to provide a concrete and specified structure for the interpretation of the situations and events.

10.3. Where does a theory come from?

Morse (1992) indicated that theory is developed from information available in the form of knowledge from various disciplines such as sociology, psychology, history, or data or evidence from practice. Bryar and Sinclair (2011) suggested that theory can be developed

through deductive or inductive reasoning. Deductive reasoning is used to test out a particular theory from available knowledge. The deductive theory has been defined as the identification of concepts and theories using the deductive approach. This process involves the examination of pre-existing knowledge or theory which is then applied to the practice of midwifery (Bryar and Sinclair, 2011). This knowledge or theory may be part of the knowledge base of other disciplines, such as psychology as stated earlier, or models or theories of nursing; or from the midwifery literature (Bryar and Sinclair, 2011). On the other hand, inductive reasoning is referred to as the collection of evidence inductively as seen in qualitative research (Bryar and Sinclair, 2011). In this regard we could say that grounded theory, a type of qualitative research, is an outcome of inductive reasoning (Bryar and Sinclair, 2011). Some authors go further to classify theories into levels based on their scope, this is discussed in the next paragraph.

10.4. Levels of theory

Although various authors have used different terms, the following are commonly described: micro theories, middle-range theories, a grand theory, and meta-theory (Bryar and Sinclair 2011; George, 2011). Similarly, Chinn and Kramer (2004) as cited in George (2011, p.96) suggest that theories could also be “characterised as either micro, macro, midrange, atomistic or wholistic”. These authors further emphasised that these classifications might be arbitrary and not realistically applicable in all disciplines.

Bryar and Sinclair (2011) classify theories into levels based on their scope. These levels include micro, middle-range, grand theories, and metatheory. Keck (1989) as cited in Bryar and Sinclair (2011, p.40) defined micro theories as “the least complex theories”. They are usually limited in scope because they tend to explain a small aspect of reality (Bryar and Sinclair, 2011).

For middle range theories, Moody (1990) as cited in Bryar and Sinclair (2011 p.41) defined middle-range theories as: “those that examine a portion of reality and identify a few key variables: Propositions are clearly formulated, and testable hypotheses can be derived”. Moody (1990) further explained that middle-range theories are generally the product of qualitative studies in which data are collected about a specific area or phenomena. Key concepts are identified from the generated data and clarity are made about the relationship between the different concepts (Bryar and Sinclair 2011). These relationships can then be tested through further research. Middle range theory is less broad but more concrete than the grand theories. Middle range theories are also less abstract, more empirical, practice focused, and consist of a few concepts which are written with clarity (Fawcet, 2005). Middle range theories have also been described as a

useful link between research and practice (Fawcett and Garity, 2009). They could be descriptive, explanatory, or predictive in nature and are useful in guiding nursing and as well as midwifery practice (Fawcett, 2005). The grand theory has been described as the most complex and broadest in scope. Broad theories attempt to explain areas in a discipline. Keck (1989) as cited in Bryar and Sinclair, (2011) noted that grand theories are composed of “summative concepts and incorporate numerous narrow range theories” (Bryar and Sinclair, 2011, p 41). Lastly, meta-theory, described as the last level of theory, is defined as “the analysis of theory or theorising about theory in a discipline” (Bryar and Sinclair, 2011. p.41). Charmaz (2003) suggested that the grounded theory methods are conducted to generate middle-level theories from research findings. She suggested that the resulting analysis builds its power on a strong empirical background. This analysis may further provide conceptual theories that will explain the phenomenon under study. In this regard, a generated grounded theory can then be considered as an example of middle-range theory.

10.5. How theories inform midwifery practice

Bryar and Sinclair (2011) noted that the actions of midwives are informed from the interaction of the models of childbirth and midwifery held within society, and by the individual midwife. Bryar and Sinclair (2011) reported that midwifery practice adopts a wide range of theories from many disciplines. Additionally, Price and Price (1993) as cited in Bryar and Sinclair (2011) commented, that drawing on theory from other domains, such as physiology, pharmacology, psychology or sociology could help midwives to “anticipate, interpret and react to the changes in a woman's health status during pregnancy and beyond” (Bryar and Sinclair p.29). This means that adopting theory from other areas could benefit midwives in their day-to-day practice and could also influence women's care. An example of applying theory from other disciplines is illustrated by the use of range of theories about social deprivation and health derived from sociological theory (Stringer, 2007). Similarly, motivation theory, which is drawn from psychology, is applied in care of breastfeeding women while social-political theory is explored in relation to the model of partnership in midwifery practice. (Bryar and Sinclair, 2011).

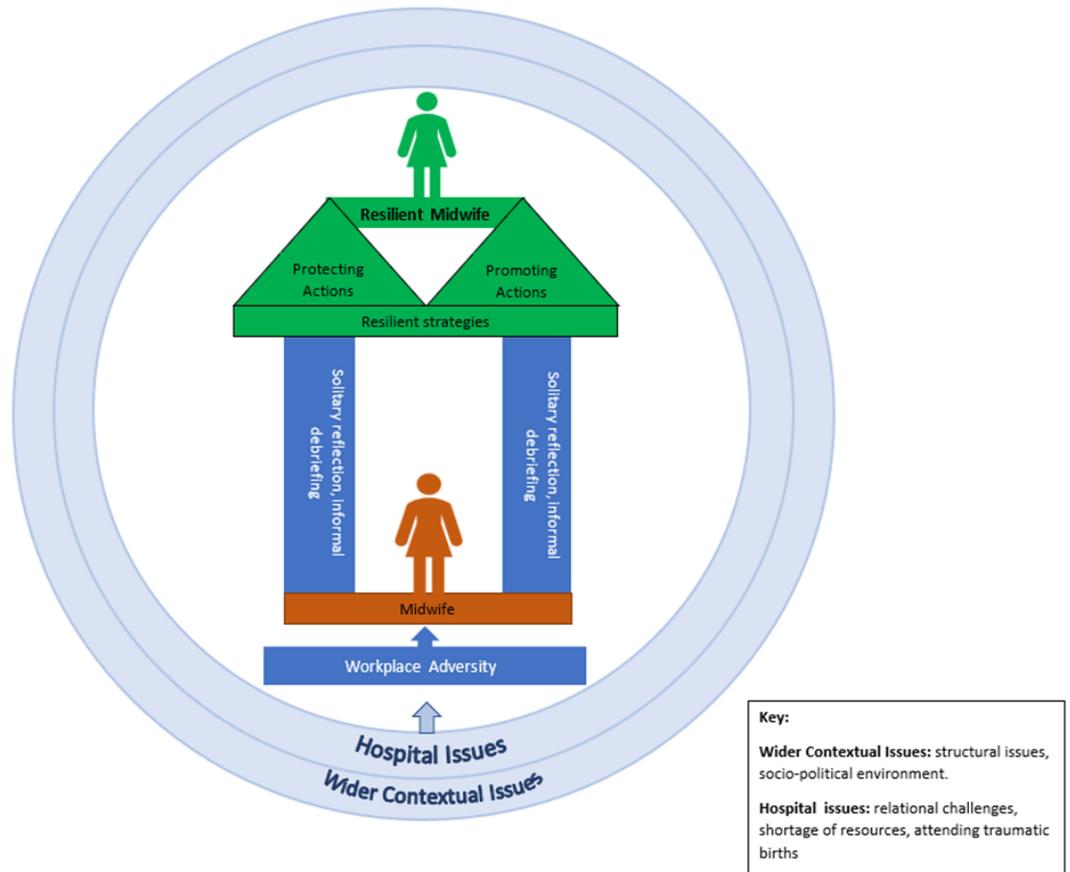
Bryar and Sinclair (2011) also put forward that theory may also be deduced from the combination of a wide range of disciplines. One example is “a combination of sociology and psychology when looking at the social determinants of health model, with theories of motivation and behaviour change to explore public health strategies” (Bryar and Sinclair, 2011, p.30).

10.6. Finding perspective: A midwives' theory of workplace adversity and resilience in Nigeria

This study aimed to develop a middle range theory of midwives' experiences of workplace adversity and resilience in Northern Nigeria. The middle range theory labelled 'Finding perspective' was generated from the data. The theory describes how midwives who experienced their work environment as difficult, utilised various strategies to remain resilient (see Figure 10.1). This theory was derived from the participants' own words as they further classified their resilient strategies into those actions that help protect and promote coping among the midwives.

This middle range theory contributes new knowledge regarding how midwives in Nigeria experience adversity and develop resilience in the face of this adversity. It is new knowledge as no study has been conducted exploring midwives' resilience in LMICs. Exploring the theory generated may contribute to a broader understanding of midwives' resilience. Moreover, it may also have specific relevance to midwives' work in LMICs because of the nature of the workplace and perhaps the similar types of adversity described in the literature. The theory and diagram will be described in the subsequent paragraphs.

Figure 10.1: Finding Perspective: A Midwives' Theory on Workplace Adversity and Resilience



10.7. An overview of the theory

The theory illustrates that the midwives in the maternity care settings within a tertiary hospital in Nigeria experienced workplace adversity resulting from poor work conditions, shortage of human and material resources, relational challenges and attending to a traumatic birth, and that they responded to this adversity by 'finding perspective' through engaging in self-care to prevent stress and burnout. This adversity was also compounded by the wider hospital issues such as the socio-political environment and other structural issues.

The self-care strategies they described included solitary reflection and informal debriefing with colleagues, these created a sense of understanding and further insight into ways of dealing with some of the difficult workplace situations. These self-care actions kept them motivated to provide care to mother and child, underpinned by their passion and love for midwifery. The theory illustrates that they drew from the following two major resilient strategies: the protecting actions which include using improvisation, spirituality, having a sense of purpose, supportive collegiality, using professional detachment; and the promoting actions which include two main actions by the participants; personal and professional development, and better remuneration.

As seen in Fig 10.1 The hospital environment and wider contextual issues contributes to midwives' experiences of workplace adversity. Workplace adversity was an aggregate of unfavourable occupational conditions and events that predisposed midwives to hardship, stress, and burnout (Jackson et al., 2007). These included micro-level issues such as juggling clinical care issues, the impact of staff shortages, inadequate resources, and relational challenges. However, there were also 'wider contextual' issues within the hospital and outside the hospital, such as poor resources, lack of policies, poor support from the organisation which contributed to the midwives' experience of adversity.

Workplace adversity was a common experience for all midwives. However, reflection and informal debriefing was used to develop some proactive and pragmatic strategies to deal with the pressure in the workplace. These strategies included the protecting and the promoting strategies which were drawn on to become a resilient midwife. Due to the multiple sources of factors influencing the resilient midwife, resilience could be viewed as a systems issue, existing at a micro level (i.e., the individual midwife) with contributory factors from the meso level (hospital and regional level factors) and macro level from national policy as well as support from other large non-governmental organisations. The findings from this study could then be viewed as supporting the social ecological

perspective of understanding resilience discussed in 4.3.3. Other component of this theory shall be described in depth from 10.7.1 below.

10.7.1. Recognising triggers to stress and burnout

The recognition of triggers to workplace stress served as a mechanism to act promptly in response to stressors. The midwives' ability to make a conscious effort to develop resilience and remain in the maternity unit as a midwife is initiated by recognising these triggers and responding to them. On the other hand, the midwives' inability to recognise these triggers may result in ineffective coping mechanisms such as leaving the unit or remaining but developing burnout. This inability to cope may lead to disrespectful care and poor quality of care, as described in many studies (Filby et al., 2017).

However, this theory suggests that initial recognition of stressors is critical to developing a resilient response. That is, a midwife needs to be able to recognise the triggers for workplace adversity in order to initiate a resilient response. There are also countless opportunities, though not always in the workplace, to decrease the midwives' experience of adversity. It is worthy of note that it is impossible to remain adversity free in the workplace (Jackson et al, 2018); therefore, using resilient strategies becomes necessary. The recognition of these triggers is influenced by solitary reflection and an informal debriefing as described in 10.7.2 and 10.7.3 below.

10.7.2. Solitary reflection

Being aware of possible 'triggers' to stress can provide midwives with the opportunity to prepare and gather resources so they are better able to deal with the source of workplace adversity. For example, if a midwife knows that a particular workplace event will be especially challenging (e.g., dealing with a difficult birth or a complicated delivery) she can implement resilient strategies, such as seeking support from a colleague to help deal with the situation at hand.

Reflection occurs following a stressful situation at work when the midwife considers the event again (Jackson et al, 2018). Reflection provides an opportunity for midwives to evaluate what they would do differently in the future and to learn from their experiences. Reflection is described in the literature as a useful mechanism for finding perspective against workplace stressors. Reflection can help an individual to learn from mistakes and can help shape one's decisions for the future (Bakibinga et al., 2012). Reflection is also about making sense of the situation after the event.

Other research in the caring professions has identified the importance of reflection (Jackson et al., 2007; Grafton et al., 2010; Kinman and Grant, 2011). Some have suggested that team reflection is essential in building resilience (McAllister and Mckinnon, 2009). In Uganda, Bakibinga et al. (2012) conducted a qualitative study aimed at exploring the phenomenon of job engagement in a group of nurses who self-identified as thriving. The study found that within this group there was a belief that nursing was a calling, this triggered a process that is mediated by introspection and reflection about their work-life, enabling the nurses to adjust and cope better on the job (Bakibinga et al., 2012). The midwives in this study found that solitary reflection, away from the place of work, was extremely useful in gaining perspective. This form of reflection was facilitated through their day-to-day activities, including walking or driving home after work.

10.7.3. Informal debriefing

The midwives used informal debriefing to identify particular stressors by discussing them with colleagues in the workplace. Debriefing has been described as an essential form of processing for healthcare workers whereby stressful events or crises are discussed with colleagues (Jackson et al, 2018). This aligns with the findings by Cameron and Brownie (2010) in their study on enhancing resilience in registered aged care nurses in Queensland Australia, debriefing was one of the themes identified as necessary for developing resilience. The participants described using an informal debriefing with colleagues as a very important form of processing for them, this could take place in the changing room or coffee room whilst on break. The midwives reported that they used debriefing with colleagues in the process of recovering from particular workplace stressors. Some midwives described feeling slightly relieved when they shared a stressful experience with their colleagues and discussed what actions they could take to deal with a particular situation. This phenomenon is consistent with findings in the literature (Tyson et al., 2002; Jackson et al, 2018). Debriefing was described as a stress buffer for nurses in Ontario hospitals (Tyson et al., 2002). No studies were found related to this in low and middle-income countries in midwifery. Thus, more research around informal debriefing may be required to affirm its usefulness in developing resilience among midwives in low and middle-income countries. The midwives used debriefing to identify which actions brought about stress and how it could be responded to through interaction with colleagues at the workplace.

10.7.4. Responses to adversity

The integration of key resilient strategies from categories has developed the theoretical model 'Finding Perspective' (Figure 10.1). This suggests that developing resilient strategies in midwives follows a dynamic process, it involves pragmatic approaches in response to some of the structural issues causing adversity. The midwives are faced with the demand to provide quality maternity care but feel challenged by the difficult situations in the hospital setting. This is characterised by poor resources and other challenges particular to midwifery in their workplace. As a result, the midwives draw from resources within themselves (spirituality, having a sense of purpose linked to having a sense of vocation) and from external resources (supportive collegiality, using improvisation and building interpersonal relationships). All of these can be summed up as resilient strategies against the underlying workplace pressure.

The midwives identified two types of action which reduced the effect of workplace adversity: 'protecting actions and 'promoting actions', these resulted in the consequence of a 'resilient midwife' as described by the coding framework. These actions are explored in turn in the next paragraph.

10.7.4.1. Protecting actions for resilience

As illustrated, in Fig 10.1, following the recognition of triggers to stress in the hospital environment, the midwives utilised the protecting actions for resilience in the short term in the event of workplace stress. These protecting actions included using improvisation, having a sense of spirituality, supportive relationships, professional detachment, building interpersonal relationships, and having a sense of purpose linked to a sense of vocation.

The midwives considered these protecting actions to be beneficial in their initial response to the possible negative effects of workplace adversity. The midwives resorted to using improvisation when there were resource constraints, becoming 'super midwives' by for example '*wearing about four to five gloves and moving between four to five women in the second stage of labour*' to deal with the shortage of midwives. Also, they used professional detachment to help them find perspective in dealing with the stress after having attended to a traumatic birth. They drew on supportive collegiality, and built interpersonal relationships with midwives, mothers, and their relations. These actions might have been necessary for the long term, but they were also believed to be useful as an immediate response to stressors at the workplace. For example, in relation to supportive collegiality, the participants described how the positive relationships they formed with colleagues and the sense of working as a team who look out for each other,

i.e., 'watching each other's backs', acted as a protective action when stressful situations arose. Additionally, having a sense of purpose linked to vocation was important in motivating and re-energising the midwives for resilience. It was useful for coping with daily stressful situations by keeping the midwives reenergised, they felt they were working within their calling. Spirituality also contributed to the midwives' resilience in a number of ways: trusting in God's providence, praying and asking God for strength and finding comfort as well as coping following a traumatic birth.

10.7.4.2. Promoting actions for resilience

Promoting actions were institutional-based actions the midwives reported as being useful in promoting coping or strengthening resilience amongst them. These were actions that the participants reported as very important, it helped them move past some of their adversity and helped promote their coping mechanisms. Such actions are not within the individual midwife's power to control, although she could lobby for initiatives. The actions included personal and professional development, better resource management, and increasing remuneration. These mechanisms were described as useful in finding perspective of workplace adversity by developing or using effective ways to cope with the adversity experienced. The above resilience strategies support the socio ecological perspectives of understanding resilience as the midwives' resilience was developed from factors within and outside the environment.

Indeed, the professional development of midwives has also been described in the recently released State of the Worlds' Midwifery report (SoWMy) (UNFPA, ICM and WHO, 2021),. This presents findings on the state of sexual, reproductive, maternal and new-born and adolescent health (SRMNAH) workforce from 194 countries including Nigeria (UNFPA, ICM and WHO, 2021). This report emphasised the need to invest in high quality midwifery education and training of the midwifery workforce. This would improve the quality of care the midwives can provide to women and their babies, as well as to the broader area of sexual, reproductive, and adolescent healthcare.

However, it is worth noting that the midwives individualised the responsibility to develop resilience, making it a matter for individual midwives (who are then to be blamed if they are not resilient). There were several structural issues at play here, these ranged from lack of adequate and proper functioning equipment together with basic delivery items and a shortage of workforce that no amount of debriefing or reflection can address. Thus, midwives' individualising responsibility for resilience may fail if the structural problems fail to be addressed.

CHAPTER ELEVEN - Discussion

11.1. Introduction

The findings presented in Chapters Seven, Eight and Nine demonstrate the midwives' experiences of adversity and the various resilient strategies they adopted to deal with adversity. This study makes a contribution to the existing body of knowledge as this was the first study conducted which aimed to develop a unique theory, explaining how midwives experiencing workplace adversity developed resilience in the context of a LMICs. The study established characteristics of workplace adversity, its perceived effects, and responses to the adversity experienced. It also explored the meaning of resilience to the participants and the various resilient strategies adopted. It also developed a middle range theory of workplace adversity and resilience.

This chapter will discuss some of the issues in relation to the midwifery workforce in LMICs, and where necessary the literature relating to the nursing workforce. Firstly the key findings will be focused on, these were around the areas of adversity experienced and include the following responses: i) severe lack of resources – workforce, leading to excessive workload, and material resources such as equipment, water and power among others; ii) the nature of the work characterised by highly challenging maternity care settings: high number of obstetric emergencies, maternal and neonatal deaths, many women arriving in labour ward with no antenatal history; and iii) complicated relationships between the midwife, the woman and her family. The major resilient strategies used by the midwives to deal with these adversities will then be discussed. These strategies included using improvisation, spirituality, having a sense of purpose linked to sense of vocation and calling, and building interpersonal relationships. These issues will be discussed in the following sections and will draw from appropriate literature and theories to support the findings. Ways of better supporting the midwifery workforce through the adoption of relevant resilient strategies will be suggested. The table below presents the key adversities and the resilient responses that will be described in this chapter.

Table 11. 1: Showing key adversities and resilient responses / strategies

Key Adversities	Resilient response
Severe lack of resources	Using Improvisation,
Shortage of midwifery workforce	Having a sense of purpose/sense of vocation and calling.
Difficult midwife -woman interaction	Becoming a super midwife.
Attending to a traumatic birth	Building Interpersonal relationships. Spirituality,

11.2. Characteristics and experiences of workplace adversity and resilience

The adverse work situations described by the midwives, such as excessive workload, staff shortage, a poor work environment with a general lack of essential resources, unsupportive colleagues, and frequent attending to traumatic birth are well documented in current midwifery literature from around the world (Thorsen et al., 2011; Rouleau et al., 2012; Banovcinova and Baskova, 2014; Creedy et al., 2017; Mullira and Ssendikadiwa, 2016; Barde, et al., 2017; Geraghty, 2018; Suleiman-Martos et al., 2020). They are also present in studies of other health care and public service workers in HIC (Ball et al., 2002; Jackson et al., 2007; Adamson et al., 2012; McCann et al., 2013).

There is a dearth of literature exploring workplace adversity among midwives in LMICs specifically considering the nature of midwifery, where women with no history of antenatal care are often rushed in late in labour. Midwives are tasked with providing care to these women in the presence of insufficient resources, whilst struggling to provide quality care to reduce the unacceptably high maternal mortality in the country.

Most studies, that examine stress resulting from workplace adversity in Nigeria, focused on diverse health workers, including nurses. Workforce shortages, excessive workload, lack of equipment, poor management, amongst others are all well documented as a source of occupational stress for health workers (Lasebikan and Oyetunde, 2012; Olayinka et al., 2013; Onasoga and Ojo., 2013; Anyebe et al., 2014; Ladan et al., 2014; John et al., 2015; Dachalson et al., 2017; Kuforiji, 2017; Akinsulore et al., 2020).

However, the level of adversity experienced by midwives is particularly challenging due to the emotional demands of the job and dealing with two lives. Generally, midwives may have different experiences of resilience from nurses as they usually have more

responsibility and autonomy than nurses. Wright et al. (2017) remarked that, though research has described the causes of workplace stress among midwives internationally, midwifery stress varies significantly from one world region to another. They reported that, for example, what some midwives considered to be stressful in the United Kingdom may not apply to midwives' experiences in Uganda (Wright et al., 2017). Also, the factors contributing to midwifery stress vary greatly depending on the availability of resources, the structure, and the composition of the health care system. (Wright et al., 2017). However, the WHO *Midwives' Voices, Midwives' Realities* study, suggests that occupational distress is a shared burden among midwives regardless of location (WHO, 2016). This means that some common adverse experiences are shared by midwives globally but that the level of adversity experienced varies with context, particularly in relation to the economic status of the country. Despite the different causes of workplace stress, as cited in the literature, its effects take a considerable toll on the professional well-being of the midwifery workforce.

11.2.1. A severe lack of resources: workforce, workload, and material resources

The challenges of staff shortages and excess workloads among nurses and midwives are not only specific to Nigeria but have also been reported in other LMICs such as Senegal, Ghana, Uganda and Malawi (Adzakpah and Bradley, 2009; Rouleau et al., 2012; Onasoga and Ojo 2013; Anyebe et al., 2014; Ladan et al., 2014; Dachalson et al., 2015; Bradley et al., 2015, Godwin et al, 2016).

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 the 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). Another study in Ghana demonstrated that workload was a source of extreme pressure to the midwives (Mbatudde et al., 2020).

From the women's perspectives, the issue of staff shortages and excess workload were further confirmed in a study exploring women's perceptions of the workloads of maternity health professionals in health facilities in Nigeria (Ogu et al., 2016). The women in the study attested that the health providers in maternity units, including midwives, were overwhelmed with heavy workloads leading to the provision of poor-quality care. These authors also added that women using maternal health services in the northern geopolitical zones in Nigeria were more likely to report high workload as a major problem, compared to other women in the southern geopolitical zones (Ogu et al., 2017). This was attributed to the shortage of human health resources in the northern zone, compared to the southern parts of the country (Galadanci et al., 2007, Nyango et al., 2010). This confirms the findings explored in the current study, which is situated in the northern part of Nigeria. A shortage of maternity health workers, including midwives, may jeopardise the universal access to high-quality maternal care necessary for achieving sustainable goal 3 (Ogu, et al., 2017).

It is important that stakeholders develop a policy of sustainable human resource development that promotes the recruitment, distribution, and retention of health care workforce, especially the midwives who deal with maternal health care and potential maternal mortality in Nigeria. This will ensure that all health facilities, including those in hard-to-reach PHC's in the community, are covered. This may be important for achieving universal health coverage, as investment in quality primary health care has been described as fundamental to achieving universal health coverage around the world (WHO, 2019). Such investment is considered to be the most cost-effective way of ensuring that access to essential health care, including basic emergency obstetric care, is improved (WHO,2019).

Therefore, a total restructuring of services to improve the functioning of PHC's is necessary to increase the number of facilities which provide essential childbirth care (i.e. for all births) plus basic emergency obstetric care. Hence, the likelihood of reducing the workload on tertiary health facilities which can then focus on providing more comprehensive emergency obstetric care.

Workload is the most critical predictor of staff burnout and poor attitude towards patients (Shirom et al., 2010). Even if burnout is not experienced, it is a significant cause of dissatisfaction among health caregivers which influences staff decisions on whether to leave or remain in their jobs (Shirom et al., 2010). Already burdened by a high maternal and infant mortality rate and heavy workloads, among other challenges and inadequate resources necessary for the provision of high-quality care, the midwives in this study were left feeling frustrated and poorly motivated. The situation for these midwives' echoes findings from a global consultation with 2,470 midwives in 93 LMICs, including Nigeria. The results of this study showed that midwives experienced difficult work situations due to

shortage of staff, heavy workloads and high levels of maternal and new-born mortality rates. 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). 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. Staff shortage is also a 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. This study extends the understanding of the frustration's midwives endure by providing additional detail about how staff shortages are experienced while providing care, specifically in the labour ward and other maternity units.

In relation to the issue of resource shortages, findings from the present study were consistent with the few studies conducted in Nigeria among nurses and other health care workers (Effionm et al., 2007; Anyebe et al., 2014; Ladan et al., 2014; John et al., 2015; 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 studies from other LMICs. For example, a qualitative study conducted in Mozambique reported a lack of equipment as a source of stress and frustration (Aldolphos et al., 2016). Also, two recent systematic reviews suggested that poor working conditions and deficient essential resources such as inadequate water supply, basic sanitation, drugs, and equipment could compromise the quality of care provided to mothers and their babies (Filby et al., 2017; Munabi-Babigumira et al., 2018). 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, p.6) declared that a health-related resource constraint worsens the issue of workload by causing "time-consuming struggles to improvise" which may negatively affect maternal outcomes. 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.

Bradley and McAuliffe (2009) further wrote that a shortage of human and material resources had the biggest impact on work environment, it was not surprising that the midwives also considered these as a source of adversity. A 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). The availability of appropriate facilities and sufficient resources is regarded as necessary for staff motivation and performance (WHO, 2016). The poor work environment has been reported as among the push factors responsible for the exodus of nurses and midwives in Nigeria (Okafor and Chimereze, 2020). Therefore, it is essential that health systems 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 important for midwives to take charge or power to influence their situation (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).

Other health workers have also reported a lack of equipment as a common source of workplace stress and frustration. For example, two qualitative studies conducted among other health workers, including physicians in Togo and Ireland, reported that lack of appropriate medical equipment and supplies to care for patients was a source of stress, anger and frustration among physicians thus affecting the quality of care provided (Kpessague and Soedie, 2017; O'Dowd et al., 2018). It can be inferred that irrespective of regional or geographical differences, a lack of resources or insufficient resources created a stressful working environment for healthcare staff. However, the severity of these challenges varied between countries. Thus, the attention and efforts of policymakers in LMICs should be directed to the above factors to enhance the provision of quality maternal and infant health. This is necessary for the reduction of maternal death to 70 per 100 000 live births as well as an improved new-born death rates and the achievement of the UN Sustainable Development Goals as mentioned at the beginning of Chapter 3. Specifically, and in relation to this study is Sustainable Development Goal 3C, this has a specific focus on "...the recruitment, development, training, and retention of the health workforce in developing countries" (UN ,2015, p17).

11.2.2. Linking Lipsky's theory of the 'Street-level Bureaucrats'

Lipsky's theory of Street Level Bureaucracy (Lipsky ,1980) gives some insight into resilient strategies described by the midwives in this study. Lipsky outlines the process whereby a lower cadre of staff in human service agencies use some level of discretion to make sense of the actual public policy, this makes it possible to implement in practice. Lipsky

refers to this cadre of workers as the 'street-level bureaucrats' and defined them as "public service workers who interact directly with citizens in the course of their jobs, and who have substantial discretion in the execution of their work" (Lipsky, 1980, p.3). Lipsky argues that public policy is often not clear and precise and depends on the frontline public service workers to make sense of it at the point of service delivery. Lipsky's approach has influenced the subsequent analysis of public service provision, showing how all street level bureaucrats such as police officers, teachers, military men, judges, health workers and in this study midwives, use discretion in a particular way. The actions of street-level bureaucracies or front-line public services are guided by policies; however, they work under conditions of inadequate resources. Nevertheless, they can manage this tension by exercising discretion in their work. Lipsky argues that this cadre of staff should be seen as policymakers, rather than implementers of policy. Because a policy reform is nothing but just a mere piece of a paper until the frontline workers have delivered it to service users.

The street-level bureaucrats deliver the policy in the way that is more achievable on the ground rather than what they were told to do. In other words, this policy can be distorted because of the substantial level of discretion the street level bureaucrats have in carrying out their daily work. Lipsky commented that, "the decisions of street-level bureaucrats, the routines they establish, and the devices they invent to cope with uncertainties and work pressures, effectively become the public policy they carry out" (Lipsky, 1980, p.xii).

Street-level bureaucrats are responsible for making appropriate decisions that are specific and suitable for service users depending on their situations. Lipsky (1980) states that all street level bureaucrats will confront problems or face dilemmas in which they need to move from public service ideals to the reality of coping with both expectations from their managers and the public. Lipsky further argues that the use of discretion by street-level bureaucrats is particularly needed because of the complexity and unpredictable nature of human work in public service.

Lipsky's (1980) analysis of the dilemma of 'the street-level bureaucrats', that is, how to balance the ideals of the job with the challenges and constraints of day-to-day reality, provides an understanding of the difficulties underlying midwifery practice in the face of scarce resources and trying to achieve organisational goals in a poorly resourced hospital setting. The midwives in the current study could be considered as street level bureaucrats, which may explain the reasons for them being enormously pragmatic in dealing with their job in everyday life and their resiliency. Lipsky's theory provides an explanation of the various ways midwives use their discretion in dealing with the task in front of them, for example by using improvisation and workarounds as solutions to a shortage of both human and material resources.

The midwives frequently mentioned using “workarounds” to provide a temporary fix for problems. Debono et al. (2013, p.2) defined “workarounds as observed or described behaviours that may differ from organisationally prescribed or intended procedures. They temporarily fix an evident or perceived workflow hindrance to meet a goal or to achieve it more readily”. Improvisations or innovations are some of the terms that provide more positive meaning of workarounds. Workplace workarounds are used to solve a range of problems, including poor staffing, equipment and supplies (Debono et al., 2013).

The midwives in this study were continually faced with new problems to be resolved, such as dealing with obstetric emergencies in the presence of a shortage of human and material resources, and women rushed in late in labour with no birth items; such situations demand that they move beyond their normal routines. These workplace demands ensure that midwives in this context need to be enormously pragmatic in order to deal with the unpredictable nature of their work. This pragmatism manifested in how scarce physical and human resources were used. The insights provided by Lipsky in his conceptualisation can give some explanation of midwives’ responses when faced with scarce resources. Using such strategies as improvisation explains what Lipsky (1980, p.14) has suggested, that ‘in order to practise in more professionally acceptable ways the street-level bureaucrats attempt to resist the organisational structure by creating their own working rules’. This means the front-line workers (the midwives) create rules that protect them whilst enabling them to care for the women. Lipsky concluded that the lack of resources caused street level bureaucrats to develop simplified routines when dealing with issues that affected their everyday tasks. The midwives used workarounds to deal with the stress associated with a lack of appropriate equipment and other resources in the labour ward. For example, in the labour ward, they reported the benefits of using improvisation and tactics such as dashing between women in labour regularly, wearing several pairs of gloves i.e. ‘becoming a super-midwife’ as described in 7.3.2 when they have to attend to five birthing women and move between these women. This helps them deal with work overload, as described by the participants.

Participants mentioned they ‘have to make do’ with what they have in order to save mothers and babies under their care, such as the use of plasma expanders in place of blood transfusion. The midwives were aware of the limitations of using some of these measures but felt compelled to find alternative ways to save lives when ultimate responsibility for extremely vulnerable patients lay with them. By using such strategies as improvisation, the midwives in this study have attempted to perform their midwifery roles in a more covert way with the spirit of professional pragmatism instead of confronting the maternity care system directly.

11.2.3. The challenges of having a difficult midwife-women interaction

Some of the difficult workplace environmental elements that impacted on midwifery practice, mentioned in the previous section, also affected the interactions between the women and the midwives. For instance, some participants disclosed that due to the heavy workload, negative emotions like anger and frustration sometimes emerged in their responses. This occurred during midwife - women interactions as discussed in section 7.2.3. It can be inferred that there may be a link between stress and burnout and the mistreatment of women during childbirth or disrespectful midwifery care, as reported by many studies (Chen et al., 2004, Bohren et al, 2014; Bohren et al, 2015; Bradley et al, 2016; Filby et al., 2016; Bohren et al., 2019; Dahab and Sakellariou, 2020). These findings were less common in studies of midwives' experiences of workplace adversity in high-income countries. Therefore, 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.

Disagreements with the patient and their relatives leading to verbal or physical violence is a known stressor for nurses (Gates et al., 2011; Adriaenssens et al., 2015) and it may also affect midwives (Cramer and Hunter, 2019). Banocinova and Baskova (2014) reported that conflict with women and their families had a moderate correlation with emotional exhaustion for the midwives. Mbatudde et al. (2020) also described problems with patient and family as a source of extreme stress for the midwives in Uganda.

One precipitant of the difficult interaction, frequently cited by midwife participants in the current study, was the cost of care/out of pocket payment and not being prepared for the birth due to poverty i.e. not having the required items which the woman is expected to bring with her such as baby clothes, diapers, and other birth items. This is not surprising because the cost of care and out of pocket payments, or direct payment, for health care is the major source of health expenditure in Nigeria. It is estimated that out of pocket payments constitute about 60% of total health expenditure in Nigeria (Uzochukwu et al., 2015; Michael et al, 2019). Although access to health insurance is common for some employees in the civil service, many people still have to pay out of pocket for healthcare expenses, this may be expensive. In Nigeria, many patients are presented with a bill at the time of their visit and required to pay before leaving the hospital. A combination of inadequate birth preparedness and the payment of costly healthcare, often hinders the midwife-woman/women's family relationship as described by the participants. Kumar et al. (2016) in India also confirms that increasing out of pocket payment has hindered the relationship between the health workers and the patients. They contend that violence,

including verbal abuse within the hospitals, has been recognised as a significant issue for health service providers in LMICs where the individuals are supposed to pay for their health expenses which may at times be costly.

Furthermore, some of the midwives considered physical abuse as part of the job. One of the participants in this study said, '*some of us were even being slapped, and then what do you do, it's part of the work*'. This may be due to the relatively low status of midwifery intersecting with the gendered, predominantly female, nature of the profession and women's lack of power within the political system. (WHO, 2016; Filby et al., 2016). Harassment of midwives while at work, including physical and verbal abuse, has been reported as a social barrier to provision of quality midwifery care by two large studies (Filby et al, 2016; WHO, 2016). This may affect the self-worth of these midwives and may influence the quality of care provided (WHO, 2016; Filby et al., 2016).

The findings from the current study have also been reported in other studies. For example, in Morphet et al. (2019) study on managers' experiences of prevention and management of workplace violence against health care staff in Australia; participants reported the frequency in occurrence of workplace violence, and this was accepted as 'part of the job', and rarely reported. This finding has previously been identified by other studies (International Council of Nurses, 2007; Hogarth et al, 2016).

On the part of the women, difficult relationships with midwives may influence their choice of health care facility as well as the decision about whether to give birth at a facility or not, as found elsewhere in Tanzania, Ethiopia (Kruk et al., 2009; McMahan et al., 2014; Bradley et al., 2016) and even in Nigeria (Ogu et al., 2017). This may worsen maternal and infant death, as births are rarely attended by a skilled birth attendant outside of a health facility (Ten Hoop-Bender et al., 2014), thereby increasing the maternal and infant mortality rate of the country.

11.2.4. Dealing with a difficult birth and 'uncooperative women'

The midwives described dealing with complicated deliveries, such as shoulder dystocia, postpartum haemorrhage and providing resuscitation to an asphyxiated baby, as a source of anxiety due to lack of competence in managing such complications. Many of the participants reported a lack of training and updates in evidence-based practice in midwifery as a cause of the lack of confidence and competence. This echoes the findings from a recent study by Bogren et al. (2020) aimed at exploring the challenges and factors that motivate midwives' retention in their workplace. Their study declared 'insufficient competence' for managing difficult birth as a challenge with a resultant negative effect on

the midwife's well-being. The midwives in the Bogren's study also blamed a lack of regular training and reported the need for retraining programmes to improve their confidence and competence. A lack of confidence and competence in managing difficult births may result in delays when caring for a mother and may lead to an avoidable loss of life. On the part of the women, hearing about a maternal death during a supervised birth in the hospital may influence the expectant mothers' perception of safer intrapartum care (Adjei, 2015). This may contribute to low uptake of skilled birth attendant services and a delay in making the decision to access care, this can lead to maternal and neonatal mortalities (Calvello et al., 2015). Hence the need for frequent update and training of midwives for quality midwifery care is non-negotiable. Midwives must be valued for their work, and strategies implemented to retain them through improving their educational experience and working conditions (WHO, 2019).

Similar to the midwives in this study who described a 'lack of cooperation' from some women in labour, this was also a source of stress for some midwives in Uganda and Malawi as they described struggling with 'difficult' mothers during labour (Bakinbinga et al., 2012; Balde et al., 2017; Bradley et al., 2019). A systematic review by Bradley and colleagues explored midwives' perspectives on the drivers of disrespectful intrapartum care during facility-based delivery in sub-Saharan Africa. They 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 the current study also described women as being challenging to manage 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). The authors found that the trigger point was that the midwives needed to feel in control of pushing. 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). 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. However, some resilient strategies for better supporting women during intrapartum care are discussed in the subsequent paragraph.

11.2.5. Building an Interpersonal relationship

Communication and interpersonal skills are vital tools for effective health care delivery (Hobgood et al., 2010). The participants in this study emphasised the importance of building interpersonal relationships to cope with workplace stress and resilience. Communication and interpersonal skills are valuable for relationship building and creating positive workplace relationships among midwives and other colleagues in the maternity unit, as reported in studies of midwives in DRC and the USA (Bogren et al., 2020; Foster et al., 2018). Furthermore, increased motivation among midwives was reported as a consequence when better communication was established with women and their families, as seen in the humanised birth intervention in Benin (Fujita et al., 2012)

Additionally, when women in labour are treated with courtesy and respect, using appropriate communication skills, they participate actively in their care and this may lead to a positive midwife-woman relationship, thus reducing adversity for the front-line worker. Building relationships with the women and their family has been described as important for sustaining resilience in midwifery. For example, Crowther et al. (2017) studied the sustainability of resilience among midwives and identified themes including their own decision-making, the importance of building professional relationships with the women and their families, self-care and passion and love for midwifery as important in midwifery resilience. Additionally, Shakibazadeh et al's review, which was conducted in order to develop the conceptualisation of respectful maternal care, revealed that women and healthcare providers emphasised the significance of effective communication as a vital component of respectful maternity care globally (Shakibazadeh et al., 2018). This may increase the use of skilled birth attendants leading to a reduction in maternal and infant mortality rate in Nigeria.

11.2.6. Attending to a traumatic birth

The World Health Organisation (WHO, 2012) reported that midwives working in low resource settings in LMICs are frequently exposed to traumatic births. Exposure to traumatic birth can result in compassion fatigue, secondary traumatic stress, and in some cases, post-traumatic stress disorder (Leinweber and Rowe, 2010; Rice and Warland, 2013; Beck et al., 2015; Leinweber et al., 2017; Schroder et al., 2016). Studies identified that midwives who had witnessed traumatic incidents in the birthing environment in an

HIC experienced higher levels of psychosocial health problems (Mollart et al., 2013; Sheen et al., 2015; Larsen et al., 2016), this was due to the emotionally demanding nature of their work. For example, the finding of Rice and Warland (2013), where the participants reported feeling responsible for women and babies' outcomes, they repeatedly questioned what they could have done differently to prevent a traumatic birth, this supports the findings of this study. The feeling of empathy for the women emerged as a significant factor in midwives' experiences of witnessing traumatic birth, supporting the findings of the present study. The findings from this study also corresponded with studies by Dartey et al. (2019) in Ghana, and Mwetesise et al. (2020) and Mbattude et al., (2020) in Uganda where the participants recalled their experiences following a maternal death as a source of extreme challenge. They reported lack of concentration, inability to forget the deceased and denial of the death as feelings associated with experiencing a traumatic birth. The participants also reported feeling severe anxiety when dealing with a difficult or complicated birth due to their previous experience of traumatic birth. These feelings were related to all traumatic births whether it involved maternal death or infant death. This feeling may be hardly surprising as Figly (1995), as cited in Rice and Warland (2013, p.1056) writes that "a common theme through all traumatic birth experience is that there is a cost to caring [because] professional who listen to clients' stories of fear, pain and suffering may feel similar fear, pain and suffering because they care".

Research suggests that caring roles are associated with 'secondary traumatic stress', post-traumatic stress disorder and burnout. Leinweber and Rowe, (2010, p.76) study on '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 patient, interferes with the general well-being and performance of midwives. Burjo and WHO (2010) collaboration emphasised the importance of occupational wellness for all, to enhance mental health at the workplace. This study established that midwives experience stress when dealing with maternal and neonatal related deaths despite its prevalence in the setting. Stakeholders must understand that continued lack of psychological support for midwives may lead to poor maternal health outcomes or midwives who cannot cope may leave the profession. Therefore, some individual strategies used in dealing with these stressors become essential and important to support the midwives. One of the strategies is described below.

11.2.7. The influence of spirituality and faith

Globally, spirituality has been documented as part of resilience or coping strategies that nurses utilise to navigate through challenging situations in their workplace (Ablett and Jones, 2007; Rose and Glass, 2008; Vinje and Mittelmark, 2008; Cameron and Brownie, 2010; Ekedahl and Wengstom, 2010; Shinbara and Olson, 2010; Marie et al, 2016; Sabzevari and Rad, 2019). Although it was an unexpected finding in the current study as the participants were not asked specifically about faith, most of the participants described the importance of their religious beliefs. In the current study spirituality and religious coping were significant sources of comfort while attending to a traumatic birth.

Furthermore, spirituality has also been documented as a protective mechanism for nurses when dealing with difficult workplace situations in LMICs countries (Nderitu, 2010; Bakibinga et al., 2012; Bakibinga et al., 2014; Anyebe et al., 2014; Ladan et al., 2014). For instance, having faith in God has been mentioned as a protective mechanism for nurses while providing care in Uganda (Nderitu, 2010; Bakibinga et al., 2014). Bakibinga et al's (2014) study further illuminated the various ways in which faith in God was exhibited through such activities as prayer and meditation, and frequent visits to worship at churches, these were described as useful for well-being and for thriving on the job.

The importance of spirituality for developing resilience is one of the study's original contributions to knowledge. The feeling of religious connectedness manifested itself as spiritual practices such as praying or reading the Quran or Bible at the workplace and home. The essence of these prayers was described by all participants as a means of connecting to faith for strength. Spirituality has been described in a review article as a means of promoting the mental well-being of health care professionals (Riley, 2003; Rose and Glass, 2008). Cameron and Brownie (2010) reported that having a spiritual frame of reference was a characteristic of resilient nurses. Other studies also found that having a self-care technique, such as spirituality, can improve the level of resiliency in nurses (Mealer et al., 2012; Ang et al., 2019).

Spiritual coping strategies were a common practice among the midwives in this study as most of them reported having religious faith. Therefore, it was not surprising to find the midwives appealing to God or Allah for help, strength, or relief of tension. Islam and Christianity are the predominant religions in Nigeria. These religions provide some advice on using faith for stress reduction and also for strength during a difficult period. From a scriptural point of view, the bible promotes dealing with every problem or difficulty through prayer rather than worrying about it which may further compound the stress experienced (Bible King James Version 1982; Philippians 4: 6-7). Also, Muslims believe in appealing to

God for strength for all actions and the reward of serving humanity through caring (Quran: 53:39-42; 2:255). It was against this spiritual backdrop that the midwives explained why they often offered prayers of hope for reducing stress, anxiety, and the strength to work. In support of this, it was stated that people with religious beliefs might be able to draw on divine assistance to help them cope with stress that is impacting on their health and well-being (Kuforiji, 2017). This was consistent with the findings of Anyebe et al. (2014) and Ladan et al. (2014), where connection to God for faith through prayer was an effective method of coping with stress for nurses in Nigeria. Overall spirituality or religious coping may enhance resilience in some health care workers, especially those with religious beliefs, through prayers and meditation.

11.2.8. Having a sense of purpose and meaning: The importance of vocation and passion for the work

Vocation means an individual's conviction that one has been called to carry out a specific occupation, they have been chosen in some sense to serve humanity or they feel drawn to this work due to particular qualities they have to offer. Vocation among nurses or midwives means a firm commitment or dedication to caring for someone who requires care in some way and the nurse or midwife responds to this with personal virtues of compassion, respect and concern (White, 2002). Calling and vocation are used to refer to a "sense of purpose or direction that leads an individual toward some personally fulfilling and socially significant engagement within the work role, sometimes with reference to God or the divine, sometimes with reference to a sense of passion or giftedness" (Bryan and Ryan, 2009, p.424). The importance of a sense of purpose and meaning has been mentioned in many studies of resilience in a range of fields, including among nurses in the UK, USA and Australia (Ablett et al., 2007; Dolan et al., 2012; Hudgins et al., 2016) and midwives in the UK (Hunter and Warren, 2014). Although a negative element of this sense of vocation may be that the person puts up with difficult work conditions, toughening up and not being allowed a voice and this may affect the well-being of the midwife in the long term.

However, regarding the sense of calling or vocation, the participants described midwifery as a calling, that is a sense of vocation rather than what they do for a living. The participants shared stories of feeling motivated and re-energised due to working with a sense of purpose or calling, as supported by the work of Hall and Chandler (2005). These descriptions by the midwives also corroborate with the argument made by Dawson (2005, p.36), that in the 20th century, the meaning of calling or vocation is a reflection of the 'search for meaning and purpose in life'. Hall and Chandler (2005) argue that when

individuals are working within their calling and are facing difficult situations, they are more likely to cope because their underlying inner direction helps them navigate through, they have the belief that they will succeed.

In relation to LMICs, Bogren et al's (2020, p.4) study in the Democratic Republic of Congo reported that the midwives' "source of motivation was from their belief that midwifery is not just a profession; it's a calling which included saving lives through midwifery skills, building relationships with the women and having professional pride". The importance of having a sense of a calling has also been documented as useful for job engagement and resilience in studies among nurses and physicians from across the world (Vinje, 2007; Vinje and Mittelmark, 2008; Babikinga et al., 2012; Torres, 2019; Williamson, 2019; Serwint et al., 2019;). In Uganda, Bakibinga et al. (2012) conducted a qualitative study aimed at exploring the phenomenon of job engagement in a group of thriving nurses. The study found that within this group of thriving Ugandan nurses, calling to the nursing profession triggers a process that is mediated by introspection and reflection about their work-life, this enables the nurses to adjust and cope better on the job (Bakibinga et al., 2012). Torres's (2019) qualitative study in British Columbia, Canada explored nurses' resilience in relation to an unhealthy work environment and a sense of purpose/calling was the second subtheme that influenced the development of resilience. The participants were said to have either directly or indirectly referred to a sense of purpose/calling throughout their interviews. A similar finding was also reported among community health nurses in Norway (Vinje and Mittelmark, 2008), which suggests that nurses' job engagement is a process resulting from a sense of calling to nursing and a further call/vocation match occurs when one enters the nursing profession. Job engagement is the end product of the calling/vocation match. A key finding from the study was that all the nurses possessed a sense of calling to the nursing profession (Vinje and Mittelmark, 2008).

Job engagement has been described as the polar opposite of burnout, with the two existing on a single continuum (Maslach and Leiter, 1997). Job engagement is characterised by energy, involvement and enthusiasm, and effectiveness while burnout is the opposite, characterised by exhaustion, cynicism, and ineffectiveness. Job engagement may not necessarily be equated to resilience, but they are both positive features needed against workplace adversity for retention of workers to avoid developing burnout.

Although Norway and Canada are HIC while Uganda and Nigeria are among the LMICs, there were obvious similarities in the experience of job engagement and resilience as revealed in the stories of the nurses and midwives from the four countries. These studies

suggest that for some nurses and midwives a sense of vocation and calling may contribute to personal resilience, so this might be worth exploring further.

With regards to the issue of passion and love for midwifery and nursing, it has been documented across studies worldwide as a significant source of comfort and resilience in the face of difficulty (Turner and Kaylor, 2015; Hunter and Warren, 2014; Cope et al., 2016b; Bogren et al., 2020; Brown et al., 2020). It has been reported that nurses who have a passion for or pride in their work and their profession are more likely to be resilient (Cameron and Brownie, 2010). The midwives in Nigeria also indicated that the aspect of their job which they loved was caring for mothers and babies. This was reflected in the accounts of the midwives as seen in section 8.3.10, many of whom described how supporting the mother to have a live baby brings a lot of joy to them and the feeling of being appreciated by the mother serves as a source of strength during difficulties. This was similar to the findings of Hunter and Warren (2014). Loving one's work (midwifery) was also a motivation for staying in the job in the study conducted in the DRC (Bogren et al., 2020).

11.3. Discussion summary

The findings from this study corroborate findings from other studies of workplace adversity. Specifically, most studies reviewed reported high patient workload, excessive and heavy workload, and attending to a traumatic birth as the significant stressors among healthcare workers, including midwives in the hospital setting. The workload issue was exacerbated for the midwives in this study due to a lack of appropriate equipment. The critical elements of the findings were discussed with reference to the relevant literature, theory and what the results mean in the context of LMICs. Furthermore, the key resilient strategies included having a sense of spirituality, sense of calling or vocation and its importance in reducing stress levels. More studies may be needed in other LMICs to support some of the findings in this study.

In the next chapter the implications of the findings for clinical practice, education and policy planning and future research and reflexivity will be described. Finally, the strengths and limitations of the study will be considered, and conclusions drawn.

CHAPTER TWELVE - Conclusion

12.1. Introduction

This chapter presents the conclusion of the thesis. It includes my personal reflections of the research process, contribution of findings to knowledge, the implications of the research findings for midwifery practice/education, strengths and limitations of the study, suggestions for future research and recommendations. The conclusion of the study is offered at the end.

12.2. Personal reflections

The decision to conduct this research was raised by personal experiences of how and why some midwives remain passionate and motivated when providing care, despite anecdotal evidence of stress resulting from their high workload and poor work environment. From my experience I also wondered why some midwives were rather aggressive towards the women they cared for, I thought they could be supported by exploring midwives' methods of coping and resiliency, especially in maternity units. A web search of coping and resilience was conducted, and I found the research by Hunter and Warren (2014) on resilience, this inspired me to conduct this study. My motivation was also underpinned by the UN Sustainable Development Goal 3, for example, 3.1 for achieving reduction of maternal mortality, 3.2 reduction of infant mortality and 3C which is targeted towards recruiting and retention of workforce. These thoughts stimulated by Hunter and Warren's study, the SDGs and personal experience informed me whilst preparing the proposal for this study.

I started to review the literature before commencement of my PhD programme for the purpose of writing a proposal to secure admission. I reviewed the literature in terms of the meaning of resilience, resilience strategies and midwifery. A literature review on workplace adversity and resilience identified a few studies conducted in HIC but limited literature was found in LMICs. The literature search found a paucity of data on midwives' experiences of workplace adversity and resilience. In midwifery literature, only a small number of studies have elaborated on this topic. In LMICs, most studies have described nurses' stress and resilience rather than that of the midwives. However, midwives have more autonomy and responsibility than nurses so perhaps may have more ways of coping than nurses. I was concerned by this gap in knowledge and felt the urge to explore the causes of midwives' workplace adversity and how some of them manage this difficult situation so as to support and motivate other midwives.

Very few studies have investigated midwives' experiences of workplace adversity and the resilient response to the adversity experienced (Macdonald 2011; Hunter and Warren, 2014). Further reading showed that there is a paucity of literature in Nigeria around midwives' experience of adversity and resilience, and this has remained under-explored until this study. This made me felt excited and curious about finding out what novel finding could support midwives to cope better in their workplaces.

The research questions were then developed, these aimed to explore how Nigerian midwives developed professional resilience in the maternity care system. This was a rather challenging period for me to arrive at the research question and also the methodology. Understanding grounded theory methods was difficult and data analysis was also challenging. I transcribed the data alone; this was the most difficult part of the data analysis stage. However, I did enjoy the process as it brought me closer to my data.

To understand grounded theory, I read a lot around it. I met with some of the students who were currently lecturers in the school to discuss their experience of using the grounded theory methods during their PhD journey. This improved my knowledge and confidence during data collection and analysis. The choice of this topic and the process of data collection has provided me with insights into the assumptions I had as a midwifery lecturer, on how midwives understand resilience, their response to adversity and the various resilient strategies they adopt. My study created an awareness of the importance of resilience and the ways health workers develop resilience, findings from this study also added to the knowledge on how midwives kept going despite the adversity they experienced at work. I am pleased that I have had this opportunity; interaction with the midwives offered a deeper understanding of how the midwives manage their lives within and outside the hospital. Initially, I had intended to use a focus group discussion to provide a means for an open discussion regarding the various resilient strategies the midwives use for navigating through their difficult workplace, but it was impossible to bring the midwives together due to the nature of their work. Although perhaps the focus group discussion might have limited the frankness of the discussions. As it turned out, the in-depth interviews provided rich insights into the midwives' experiences.

Writing up my study created challenges, especially following the death of my brother who was literally like my son and also during the pandemic, when I almost thought of quitting because of the anxiety I experienced. However, I imbibed some of the findings of my research to support me and these have help build my morale and strength.

12.3. Dissemination

As part of initial dissemination, some of the findings of the research have been accepted and presented in five international conferences (See Appendix L).

Future dissemination activities include writing papers for publication, with the aim of showcasing the midwives' social constructions of resilience and highlighting the need for focus on some of the structural issues affecting the midwives' resilience. I also intend to present my study to student midwives in Cardiff University, to help them better understand the experiences of midwives in a low resource setting and their various resilient strategies. When I return to Nigeria, I intend to give presentations and also to showcase the developed theory so as to guide and support midwives in their everyday life.

12.4. Contribution of research findings to the body of knowledge of midwifery

The findings from this study add an original and valuable contribution to the body of work on midwifery workforce resilience by providing an account of how the phenomenon of workplace adversity was experienced by Nigerian midwives and how they drew on resilient strategies to cope. By analysing the strategies midwives used for managing the adversity experienced within Nigerian maternity units, a middle-range theory of midwives' workplace adversity and resilience has been developed. This theory proposes that the predominant factors that caused midwives' adversity were shortage of midwifery workforce, resulting in work overload, severe lack of essential resources, attending to a traumatic birth, and relational challenges with both the staff and the women. It is proposed that midwives responded to these adversities by using two sets of resilient strategies: the protecting and the promoting actions for resilience.

It is important to note that the situation outlined above is not unique to Nigeria and echoes some of the experiences of health care workers globally. A shortage of human resources has also been reported in the recently released State of the World's Midwifery report SoWMY, 2021 as a source of concern among midwives in approximately 194 countries (UNFPA, ICM and WHO, 2021). Although the narratives that emerged from the study were not all negative as some of the participants identified as resilient midwives described pragmatic and proactive strategies, which they adopted to survive workplace adversity. There are several original elements that are likely to reflect the specific cultural context of this study. Spirituality was important to the midwives as they reported calling on God for strength for the job especially during difficulties, this involved invoking God through praying while at work and home. Their faith provided a 'big picture' explanation for

negative work experiences, which enabled them to make sense of these and override and come to terms with their own reactions as an individual. By focusing on the 'big picture' and positioning themselves as agents of a greater purpose (God's will) they were able to maintain their motivation. Also, the belief in God's will was a source of motivation to them during and after attending to a traumatic clinical event.

Another contribution to knowledge is that the findings revealed how midwives were struggling in their everyday life between their professional ideals and the reality of the institutional and practical demands of an under-resourced maternity unit. For example, in the labour ward, they reported how they responded to this struggle by improvising 'by wearing of five gloves' when they had to attend to five births and moving between these women at a time to help them deal with work overload. The midwives also reported using alternatives, when necessary, if equipment and instruments were not available due to inadequate resources. The midwives' work is complex and unpredictable, and they need to exercise some discretion in how they enact policies. As a result, they may need to depart from their professional ideals e.g., they may have to be detached to 'get through the work,' giving some women better quality care than others, improvising with the available resources etc.

The complexity of Nigeria as a LMICs cannot be ignored, and the findings of this thesis need to be considered in relation to this. Nigeria is a developing country with many challenges occurring in its health care system: an unacceptable maternal and infant mortality in the world and a shortage of midwives and material resources. Poverty and lack of education are significant challenges for some of the women who use the maternity services and their relations, this could result in problematic relationships with the midwives. This was often because decision making regarding accessing facility care was not always made at the right time; often it required waiting for permission from men in the family (Babalola and Fatusi, 2009; Olanade et al., 2019), thus women were rushed into the hospital late and midwives were pressured to provide emergency care amid other work pressures.

Furthermore, from a methodological perspective, the qualitative nature of this study (using a grounded theory approach) and the focus on the midwives who work specifically in maternity units makes this different from earlier workplace adversity and resilience research that focused solely on nurses in Nigeria and other LMICs. It is one of the very few studies to adopt constructivism, by using the constructivist grounded theory approach, in a LMICs, to explore workplace adversity and resilience among midwives in the maternity unit. An earlier study in Australia (Geraghty, 2018) had used the Glaserian grounded theory to explore midwives stress but the level of adversity and perhaps

resilience is likely to differ. This was in contrast to the large number of quantitative studies found throughout the literature review on workplace stress among nurses in Nigeria and elsewhere (Anyebe et al., 2014; Ladan et al., 2014;). A few studies used a descriptive qualitative design to explore resilience in nurses as seen in South Africa (Koen et al., 2011a; Koen et al., 2011b; Koen et al., 2011c, Bernade et al., 2017) and Koen, et al., (2011c) developed guidelines to enhance resilience of nurses in South Africa.

This study has not only contributed to the existing knowledge on workplace adversity and resilience among midwives but also provided more detailed insight into workplace issues and culture, occupational health and well-being, and human resource management within a Nigerian context. Thus, this research potentially adds value to the field of workplace adversity and resilience in not only the Nigerian context but also in other LMICs as well as in HIC. Furthermore, this study's findings could be transferable to a similar setting in another LMICs with similar characteristics. The developed theory can also be explored in other countries with similar workplace features and cultures.

12.5. Implications for Midwifery Education and Clinical Practice

The study implies that lack of support, experiencing difficult interactions with women and their relations, in the presence of a shortage of human and material resources predisposes to the experience of workplace adversity. The study also identified the various resilience strategies adopted by the midwives, which have implications for policy, practice and education. Based on these implications, a number of recommendations are suggested and presented in 12.8.

12.6. Suggestions for future research

The data analysis and discussion of findings, from this grounded theory approach to workplace adversity and resilience among midwives, has revealed areas for future research. There is a need for more qualitative studies among midwives working outside of tertiary hospitals such as the primary and secondary health centres and in rural settings where resources are extremely scarce. This could give further insights into midwives' resilience in a very harsh working environment. Interventional studies on the impact of continuing professional development training for midwives about causes of workplace adversity and resilience building could be conducted in LMICs. There is also scope to develop intervention studies to investigate the benefits of the use of diversional therapy such as humour or listening to music as an antidote to workplace adversity.

Although this study contributes to the body of knowledge on how the phenomenon of workplace adversity is experienced and responded to with resilience among the midwifery workforce in Nigeria, the major themes that emerged should be explored further with future international studies. This should be beneficial globally, especially in the context of midwifery in LMICs. It will enable a better understanding of the characteristics of workplace adversity and resilience among midwives and countries can look beyond their borders to address the problem. This may help in achieving one of the targets of Sustainable Development Goal 3 - to reduce maternal and infant mortality - by ensuring the health and well-being of the midwifery workforce. By better understanding workplace adversity and resilience, countries should be able to educate and retain highly resilient and motivated midwives, these are necessary, alongside other factors (e.g., structural issues), to provide the quality care needed to reduce maternal and infant mortality.

The study also indicated the importance of building interpersonal relationships between the midwife, the woman, and the woman's relatives, this could then lead to better uptake of childbirth services (antenatal, intra-partum and postnatal services). An interventional study may be required to explore midwives' knowledge and practices regarding respectful maternity care and also to explore their understanding about what actions constitute disrespect to women. The findings from such studies may help change some of their attitudes and promote positive relationships with the women thus improving a sustained use of childbirth services.

Finally, this study offered the foundation for future research needed on the most effective ways midwives could be supported in order to reduce the impact of workplace adversity.

12.7. Strengths and limitations of this research

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. This knowledge was gathered through intensive interviewing during the eight months of data collection and analysis, with some participants being interviewed more than once which allowed for deeper discussion. Also, using theoretical sampling, enriched the quality of data collected across the two hospitals. Additionally, using the grounded theory approach for data analysis, including the use of memos and maintaining a field diary, has served as an audit trail for my reflections during the PhD and the influences of my research experience on the study findings which has supported my reflexivity (See appendix J for diary extracts).

One of the limitations of this research was the small number of participants, and the study was conducted in only two tertiary hospitals and as such the experiences of midwives in settings like the primary and secondary care were not included. This would have provided a variety of experiences and perhaps other forms of resilience response. As a result, these findings may need to be interpreted with caution, as transferability may be limited. There would be a need for further research to explore this finding in a similar context. Another limitation to the study is that the data represent one geographical location and may not be generalisable across other midwifery contexts internationally. In addition, the participants were midwives working in tertiary hospital in urban areas, with no experience of midwives in rural areas captured. Also, using focus group discussions as originally planned would have provided an opportunity for an open debate and discussion about the various strategies used while dealing with workplace adversity. However, despite this limitation, the findings provide valuable previously unknown insights into the causes of workplace adversity in maternity settings and what keeps the midwives going despite the adversity experienced in a LMIC.

12.8. Recommendations

The following recommendations are based on the findings from this study and include suggestions from midwives with emphasis on how to reduce the effect of workplace adversity with the aim of strengthening resilience, which may lead to the improvement of health and well-being of the midwives. Additionally, these recommendations have the potential to contribute to meeting some of the targets of the Sustainable Development Goal (SDG) 3.1, 3.2, 3c. These recommendations will be discussed with reference to who they are directed to and where accountability should lie for any change required. In this regard, the recommendations will be structured according to micro, meso and the macro levels.

At the micro level (individual midwives)

1. The hospital management should organise frequent training for senior midwives and ward coordinators to equip them with skill for clinical supervision of junior midwives using supportive supervision and mentoring. This may motivate the midwives and potentially reduce stress and burnout which could influence the decision to stay or leave the profession. The study demonstrated the importance of workplace support for developing resilience, and how this was valued by participants. The ward managers could provide education to the team around the causes of workplace adversity and suggest some of the resilient responses including diversional approaches such as listening to music, use of humour that could benefit the midwives in their workplaces.

2. Midwives should be encouraged to take charge in decision making to influence their situation, because when they are involved in designing their work environments, it can lead to an improved quality of care for women and new-borns. 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, but the individual midwives need to be prepared to step up and take on these roles.

At the meso level (hospitals and wider context)

1. Hospitals or organisations should provide a mechanism where psychological support would be offered to the midwives following a traumatic birth experience. For example, via counselling services.

2. Various hospital should organise training emphasising on the benefits of collegial support and the development of professional networks between colleagues for the purpose of resilience. In addition, managers should provide space and opportunities for midwives to debrief with each other regularly and continuously rather than solely in response to traumatic events.

3. Organisations should channel effort towards ensuring that a break is provided accompanied by a provision of a well-furnished lounge for members of staff to relax and have an informal debriefing with other colleagues to reduce stress and promote their well-being at work.

4. Hospital managers should be proactive in the provision and availability of resources including consumables needed to provide quality maternity services.

5. There should be planned training on respectful maternity care in tertiary hospitals and also the management should address structural issues around provider workload and resources if this training is to have any impact. Regular professional and personal development should be planned at appropriate intervals to improve the competency and the confidence of the midwives. The training should be needs driven and clinical skills should be considered during rotation of midwives. This may improve staff morale and resilience and may further influence their retention. These could help address preventable maternal and new-born deaths.

At the Macro level (National level, Nursing and Midwifery Council of Nigeria, WHO, United Nation)

1. Stakeholders or the Federal Government of Nigeria must 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. There should be a thorough restructuring of services to improve the functioning of PHCs and general hospitals. 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. These facilities can then focus on providing more advanced (comprehensive) emergency obstetric care. In addition, this recommendation echoes some of the key issues emphasised by the third State of the World's Midwifery Report (SoWMy) on the need to invest in health care workforce planning and management of the workplace environment (UNFPA, ICM and WHO, 2021). It could also inform the SoWMy recommendation for investment in training of more young midwives by making midwifery more attractive, also sensitisation around the need for more midwives to the general public so as to improve the annual number of student midwives in training in Nigeria. A thorough needs assessment should be embarked upon to confirm critical structural needs as identified by midwives and prompt action should be taken to address the identified problems to improve work conditions. It is believed that improving midwives' working conditions can improve the care women receive.

2. The Nigerian Nursing and Midwifery Council, as well as other midwives' associations, should play a key role in the planning of the midwifery workforce and ensuring that midwives' workplaces are safe and well equipped for better morale and retention.

3. The midwifery education and training in Nigeria should include discussion about workplace adversity and midwives' resilience in the curriculum of both pre-service and continuing professional development for midwives in practice.

12.9. Conclusions

This study extends the understanding of the frustrations felt by Nigerian midwives, it provides additional detail about how workplace adversity is experienced while providing care in the maternity unit. It also extends understanding of how these adversities can be responded to in a resilient manner by individuals, as well as the institutional based factors which need to change to support the midwives' practice. The developed theoretical model 'Finding perspective' illustrates how Nigerian midwives construct resilience to work within a maternity care system marred with various adversities. This model has facilitated a deeper understanding of these issues with possible implications for the practice, education and policy of Nigerian midwifery. The key message from this study is about investing in midwives as a way of improving outcomes for women and babies. But investing in more midwives does not just mean training more, it means retaining them in their work and ensuring they remain motivated through resilience. Resilience of these

midwives is very necessary due to the projected shortages in 2030 (UNFPA, ICM and WHO, 2021), thus focusing on the quality of the midwifery workforce is highly recommended.

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Appendix A: Sustainable Development Goals

Goal 1	End poverty in all its forms everywhere
Goal 2	End hunger, achieve food security and improved nutrition and promote sustainable agriculture
Goal 3	Ensure healthy lives and promote well-being for all at all ages
Goal 4	Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all
Goal 5	Achieve gender equality and empower all women and girls
Goal 6	Ensure availability and sustainable management of water and sanitation for all
Goal 7	Ensure access to affordable, reliable, sustainable and modern energy for all
Goal 8	Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all
Goal 9	Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation
Goal 10	Reduce inequality within and among countries
Goal 11	Make cities and human settlements inclusive, safe, resilient and sustainable
Goal 12	Ensure sustainable consumption and production patterns
Goal 13	Take urgent action to combat climate change and its impacts
Goal 14	Conserve and sustainably use the oceans, seas and marine resources for sustainable development
Goal 15	Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels
Goal 16	Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels
Goal 17	Strengthen the means of implementation and revitalise the Global Partnership for Sustainable Development

Appendix B: Connor-Davidson Resilience Scale

Item No	Description
1.	Able to adapt to change
2.	Close and secure relationship
3.	Sometimes fate and God can help
4.	Can deal with whatever comes
5.	Past success give confidence
6.	See humorous side of things
7.	Tend to bounce back after illness or hardship
8.	Things happen for a reason
9.	Best efforts no matter what
10.	You can achieve your goal
11.	When things look hopeless, I do not give up
12.	Coping with stress strengthens
13.	Know when to turn for up
14.	Under pressure, focus and think clearly
15.	Prepare to take the lead in problem solving
16.	Not easily discouraged by failure
17.	Think of self as a strong person
18.	Make unpopular or difficult decision
19.	Can handle unpleasant feeling
20.	Have to act on a hunch
21.	Strong sense of purpose
22.	In control of your life
23.	I like challenges
24.	You work to attain your goals
25.	Pride in your achievement

Appendix C: Letter of approval for access to hospital A

13th February, 2017

Mrs Halima Musa Abdul
School of Healthcare Sciences
College of Biomedical and Life Sciences

Dear Madam,

RE: APPLICATION FOR FEASIBILITY TO CONDUCT A RESEARCH STUDY

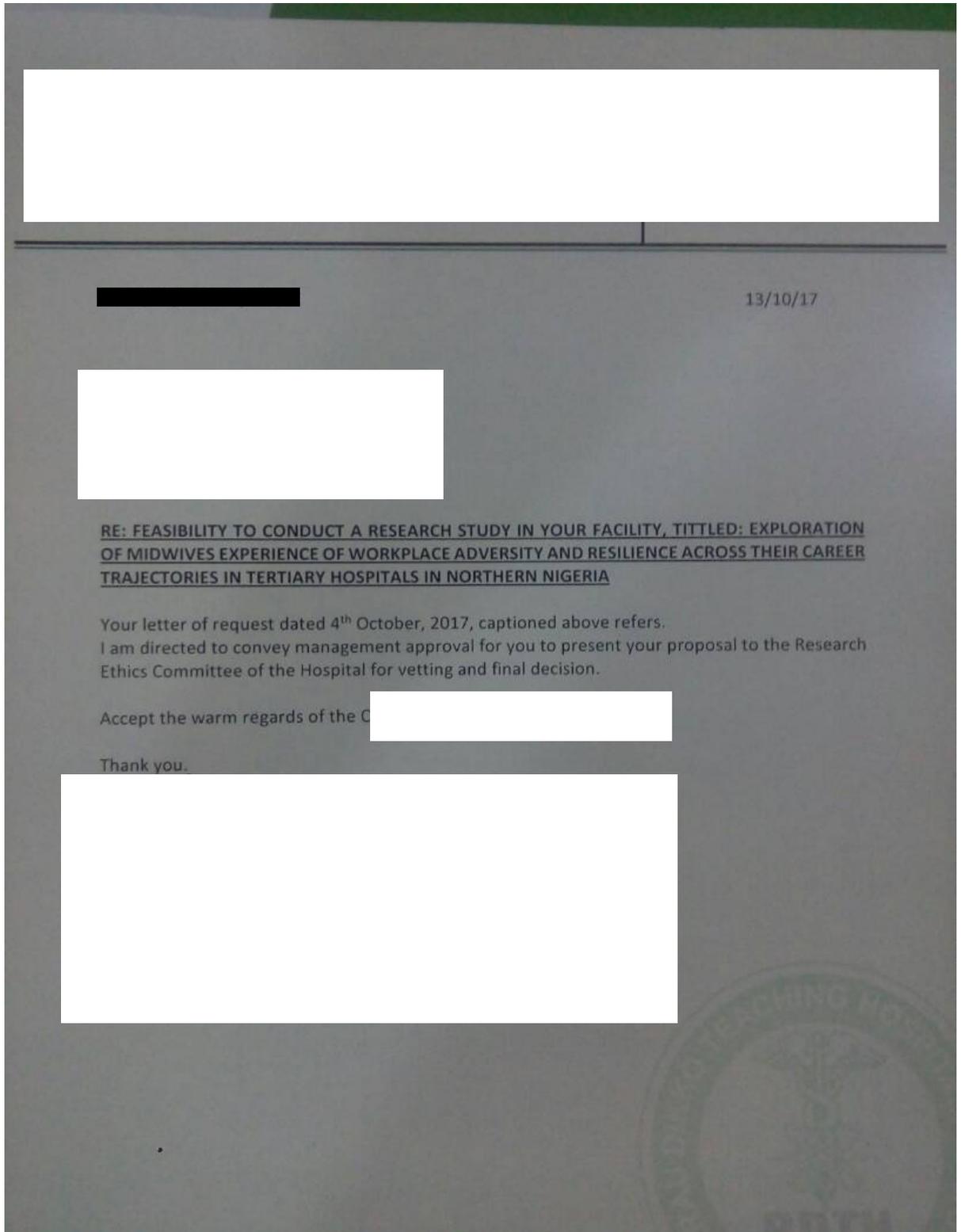
Your letter dated 9th February, 2017 refers.

_____ will permit you to conduct your study titled "**Exploration of Midwives understanding and experience of Resilience across their career trajectories in tertiary hospitals of Northern Nigeria**" in its facilities provided you obtained our local ethical committee approval.

Please extends our warmest regards and we are looking forward to interact with you.

Yours faithfully,

Appendix D: Letter of approval for access to hospital B



Appendix E: Ethical approval from hospital A

Exploration of Midwives' Experience of Workplace Adversity and Resilience in Tertiary Hospitals, Northern Nigeria.

This is to inform you that the research described in the submitted protocol, the consent forms and other participant information materials have been reviewed and **given full approval by the Health Research Ethics Committee.**

Please note: this approval dates from 4th January, 2018 - 4th January, 2019

No participant recruitment into this research may be conducted outside these dates.

All informed consent forms in this study must carry _____ number assigned to this research and the duration (_____ approval of the study.

This _____ expects that you submit your application as well as an annual report for ethical clearance renewal 3 months prior to expiration of study dates. This is to enable you obtain renewal of your approval and avoid interruption of your research.

If there is delay in starting the research, please inform _____ so that starting dates can be adjusted accordingly.

No changes are permitted in the research without prior approval by _____ except in circumstances outlined in national code for Health Research Ethics: _____;

_____ reserves the right to conduct compliance assessment visits to your research site without prior notification. *[Signature]*

Appendix F: Ethical Approval from hospital B

4th May, 2018

Halima Musa Abdul
Cardiff University,
United Kingdom.

Dear Halima Musa,

Project title: "Exploration of Midwives Experiences of workplace Adversity and Resilience in Tertiary Hospitals, Northern Nigeria".

Thank you for submitting the above research project for single ethical review. This project was considered by the [redacted] at its meeting held on the 29th March, 2017.

I am pleased to advise you that the [redacted] has granted ethical approval of this research project. The nominated participating site/s in this project is/are:

[Note: If additional sites are engaged prior to the commencement of, or during the research project, the Coordinating Principal Investigator is required to notify BDTH-HREC. Notification of withdrawn sites should also be provided to the E

The approved documents include:

Document	Version	Date
"Exploration of Midwives Experiences of workplace Adversity and Resilience in Tertiary Hospitals, Northern Nigeria".	1	10 th February, 2018

Appendix G: Ethical Approval from Cardiff University



05 December 2017

Cardiff University
Eastgate House
13th Floor
35 – 43 Newport Road

*Halima Abdul
Cardiff University
School of Healthcare Sciences*

Dear Halima

Exploration of midwives' experience of workplace adversity and resilience in tertiary hospitals of Northern Nigeria

The School's Research Ethics Committee Chair and Reviewer has considered your research proposal. The decision of the Committee is that your work should:

Pass –and that you proceed with your Research in collaboration with your supervisor

The Committee has asked that the lead reviewers' comments be passed onto you and your supervisor, please see below.

Please address the typographical and formatting inconsistencies in the Participant Information Sheet

Please note that if there are any subsequent major amendments to the project made following this approval you will be required to submit a revised proposal form. You are advised to contact me if this situation arises. In addition, in line with the University requirements, the project will be monitored on an annual basis by the Committee and an annual monitoring form will be despatched to you in approximately 11 months' time. If the project is completed before this time you should contact me to obtain a form for completion.

Please do not hesitate to contact me if you have any questions.

Appendix H: Participant Information Sheet

Title of the Study: An exploration of midwives' experience of coping with workplace adversity

Dear midwife,

My name is Halima Musa Abdul, I am a midwife and a PhD student at School of Healthcare Sciences, Cardiff University in the UK, where I am supported by experienced researchers. I would like to invite you to take part in a study about midwives' experiences of coping with workplace adversity in Northern Nigeria. Before making a decision whether to participate or not, it is important you understand the reasons for conducting this study and what your participation may entail. This information sheet aims to provide you with all the details about the study to help you decide whether or not you wish to participate in this research. Please take your time to read the following information carefully. You may also wish to discuss it with other midwives. Please contact me if something is unclear or if you would like more information.

1. What is this study about and why is it important?

Research suggests that midwives may experience high levels of stress and burnout because of workplace adversity. However in spite of this some midwives are able to adjust and cope. Understanding more about why and how some midwives are able to withstand workplace adversity and remain positive and motivated could benefit the midwifery profession in Nigeria. This study seeks to explore midwives' experiences of workplace adversity and what affects how they cope.

This study aims to add to the existing body of literature by developing a substantive theory explaining how midwives working in Nigeria cope with the stresses of work.

2. Why have I been asked to take part?

You have been invited to take part in this study because you are a midwife currently working in an obstetrics ward.

3. Do I have to take part?

No. The decision to participate in the study remains entirely yours. You are free to withdraw at any time during the study, without giving a reason. Also, if you decide not to take part now or in the future, it will not affect your work as a midwife.

4. What will happen to me if I take part?

If you choose to participate in this study, you will be asked firstly to fill in the consent form. Secondly, I shall ask you about your experiences of being a midwife, what you enjoy about work, and how you cope when you have a difficult shift. With your permission, interviews will be audio-recorded and are expected to last approximately 60-90minutes, and will take place either on the hospital premises or in a location of your choice.

5. What are the possible disadvantages and risks of taking part?

There are no significant risks or disadvantages for you if you take part in the study. However, you may find that some of the experiences described might be quite sensitive. If at any stage you feel emotional I can pause the interview process and support you. You can then decide if you are happy to continue or would like to terminate the interview. Information on further sources of support and how to access these will be made available to you.

6. What are the possible benefits of taking part?

Taking part in this study may not be of any direct benefit to you. It will however provide the opportunity for your experience of coping with workplace adversity to be discussed. It will contribute to the body of midwifery knowledge and as such may help other midwives in the future.

7. Will my taking part be kept confidential?

Information about you will be kept confidential. Your identity will remain known only to me. The audio interviews will be transcribed (typed-up) verbatim and pseudonyms will be used to protect your identity. In line with the university policy the audio recorded interviews and anonymised transcripts of the interview will be used only for the purpose of this research and be held securely for the duration of the study. At the end of the study the results will be published in nursing and medical journals and the study will be presented at nursing and midwifery conferences. The completed PhD thesis will be submitted to Cardiff University. Only anonymised verbatim quotes will be used in the writing up of the study.

8. Will anyone else know I am doing this?

Your participation in this study is completely voluntary and your participation will not be shared with anyone else. Details such as your name, workplace and contact details will be kept confidential throughout the study. Pseudonyms will also be used to ensure your identity remains confidential. Information will be only shared with my academic supervisors at Cardiff University. The study may be presented at conferences and in published journals, but your identity will not be shared.

9. Who is organising and funding the study?

This study is supported through a funded PhD studentship from Cardiff University, in the United Kingdom.

10. Who has reviewed the study?

The study has been reviewed and approved by the School of Healthcare Sciences Research Governance and Ethics Committee at Cardiff University. It has also been reviewed by the Health research committee in Nigeria.

11. What if something goes wrong?

I do not expect any harm as a result of your taking part in this study but if in the process of the interview any unresolved unprofessional or unethical conduct was disclosed that you might have been involved in or if I notice any, I shall report the conduct to the appropriate authorities for necessary action. However, if you are not happy about any aspect of the study, please feel free to contact me on the details below.

Contact address and information.

Thank you for considering taking part in this study. If you need to contact me, you can do so at the address and number below:

Appendix I: Consent Form

Participant Code:

Title of the study: Exploration of Midwives experiences of coping with workplace adversity

Name of the researcher: Halima Musa Abdul

Please read each section carefully before you initial each box.

Please initial

Each box

I confirm that I have read and understand the participant information sheet (dated x), for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily	
I understand that my participation is voluntary and that I am free to stop the interview and withdraw from the study at any time without giving a reason	
I understand that the interview will be audio recorded and I consent to the use of anonymised quotes from the interview in the writing up of the study.	
I understand that if, during the interview, information is disclosed that may put me or others at risk, the appropriate individuals will be informed.	
I understand that all information collected about me will be treated in strict confidence and will not be transferred to any other organisation	
I agree to take part in the above study	

Declaration by participant:

I hereby consent to take part in this study:

Name of Participant: ----- Date: ----- Signature: -----

-Declaration from the researcher:

I have given a written explanation of the research project to the participant and have answered the participant's questions about it. I believe that the participant understands the study and has given informed consent to participate.

Name of Researcher: ----- Date: ----- Signature: -----

2 COPIES, one for the Participant and one for the researcher's file

Appendix J: Showing examples of Initial coding of data.

Transcripts	Initial coding
<p><i>But some of them [referring to the senior midwives] they will just relax like the senior ones when you are working with them, they will just relax, they will allow you to be doing almost everything so you will be so tired, only you! they cannot help you to do anything so you will be tired, so exhausted, so that is the negative aspect of them [colleagues]</i></p> <p><i>The quality-of-care hmmm! honestly is soo poor, is not good enough because, like I say there is no man power, you cannot concentrate on your patient [a woman], most times we miss a lot of information from the patient because you have so many patient to take care of, you don't have the listening ear to listen to!</i></p> <p><i>I will say it is a work that I know I must work, and I know this work [providing care to all mothers} as a midwife is only God that will reward me. I do it with my heart and mind, so I don't get tired, and I know that when I get home, I pray for God for support, and God has been helping me to cope with stress.</i></p>	<p>Having poor collegial support</p> <p>Having poor collegial support</p> <p>Feeling exhausted</p> <p>Delivering poor quality care</p> <p>Having a shortage of staff</p> <p>Paying poor attention to the women</p> <p>Having a heavy workload</p> <p>Believing in faith</p> <p>Praying to God or support</p>

Appendix K: Example of Focused (Frequent reoccurring code from the Initial coding).

Transcripts	Initial coding	Focused Coding
<p><i>When we have more than two, three patients, four women, and a woman may also be pushing, I normally wear about four gloves, if the place is busy [...] if I collect a childbirth and another woman is pushing, and one has delivered, I will just remove the outer layer glove and, discard, already I have sterile gloves still under. I can now conduct another delivery. This is how we normally do sometimes too. (Mariya)</i></p>	<p>Becoming a super midwife</p>	<p>Becoming a super midwife</p>
<p><i>Five gloves! 'Five pairs of the glove,' five here, five here and anticipating the childbirth, which one, whatsoever one comes first, conduct this one, deliver the placenta, keep the woman comfortable in bed. Then you go to the next woamn, continue [...] when I have two or more women approaching the second stage [Childbirth], I must get them prepared all of them. (Bianca)</i></p>	<p>Becoming a super midwife</p>	<p>Becoming a super mid wife</p>

Appendix L: Raising Focus Codes to Theoretical Codes

Focused Codes	Theoretical coding/Category
Having a sense of spirituality Using Improvisation Using diversions Keeping fit for the job Having a sense of purpose	Managing and Thriving (Resilient strategies)

Appendix M: Extracts from Memos

28th/06/2018

Understanding the meaning of resilience.

Some of the participants are not aware of the term resilience. I had to explain that it could be termed as way of coping or dealing with their day-to-day activities in the maternity unit or as a midwife.

Spirituality as a focused code

Faith was mentioned severally when talking about resilience. The midwives depended on their faith most times for dealing with their activities in the unit as a source of comfort while on the job. They also talked about it on how it has supported them especially when there is a loss of life either a maternal or a neonatal death. Spirituality is a very key factor to them for coping through the job.

Becoming a super midwife.

This code appeared very useful because almost all the midwives described how they have to dash between four to five women in labour due to shortages of staff. This appeared stressful from their body language and expression of the experience. This code struck a chord immediately while they mentioned this experience.

Using a professional detachment.

Most of the midwife described how they have to put behind the loss of life while at work and they provided reason why they have to do this so as to be able deal with the next birthing woman. This may be grouped under the resilient strategy following a traumatic birth experience. This seems useful for the midwives as they all emphasised on this from their body language and while describing the experience

Appendix N: Extracts from Field diary

8th/1/2018

It was my first day with the midwives in hospital A. I tried to be relaxed though a bit nervous, I introduced myself and my research though I gave them the participant information sheet which clearly stated the purpose of the study.

The midwives were all happy about the study aims and objective all showed interest. They all indicated that they will be available anytime but will contact me to let me know.

16th/1/2018

As the interviews progresses, I realised that most participants remember some issues after the recording or after the interview. I wrote these discussions on my field diary which I decided to use as a source of data which will be presented along the data from interviews were necessary.

Additionally, some of the participants wanted the interviews on the same day, I explained that the data from an interview will have to be transcribed and analysed before the next interview as required in the particular methodology. They all agreed and understood.

22/04/2018

One of the midwives described as resilient in hospital A was contacted and she was able to provide information regarding other resilient midwives especially those she had worked with on the same shift. She was interviewed and she gave interesting information.

16/06/2018

Interviews in the Hospital B is still ongoing, the midwives appeared busier and most of them are busy most times and have cancelled their interviews for more than three times. I was patient and agreed for another date. Most of them agreed that the interview should be conducted at home and a date and time was set aside for this.

22/07/2018

Discussing my field experience with my supervisors were always useful for me as a form of debriefing. This usually supports me and help me deal with some of the distressing accounts of the midwives' experiences and even some of my personal experience while on the field.

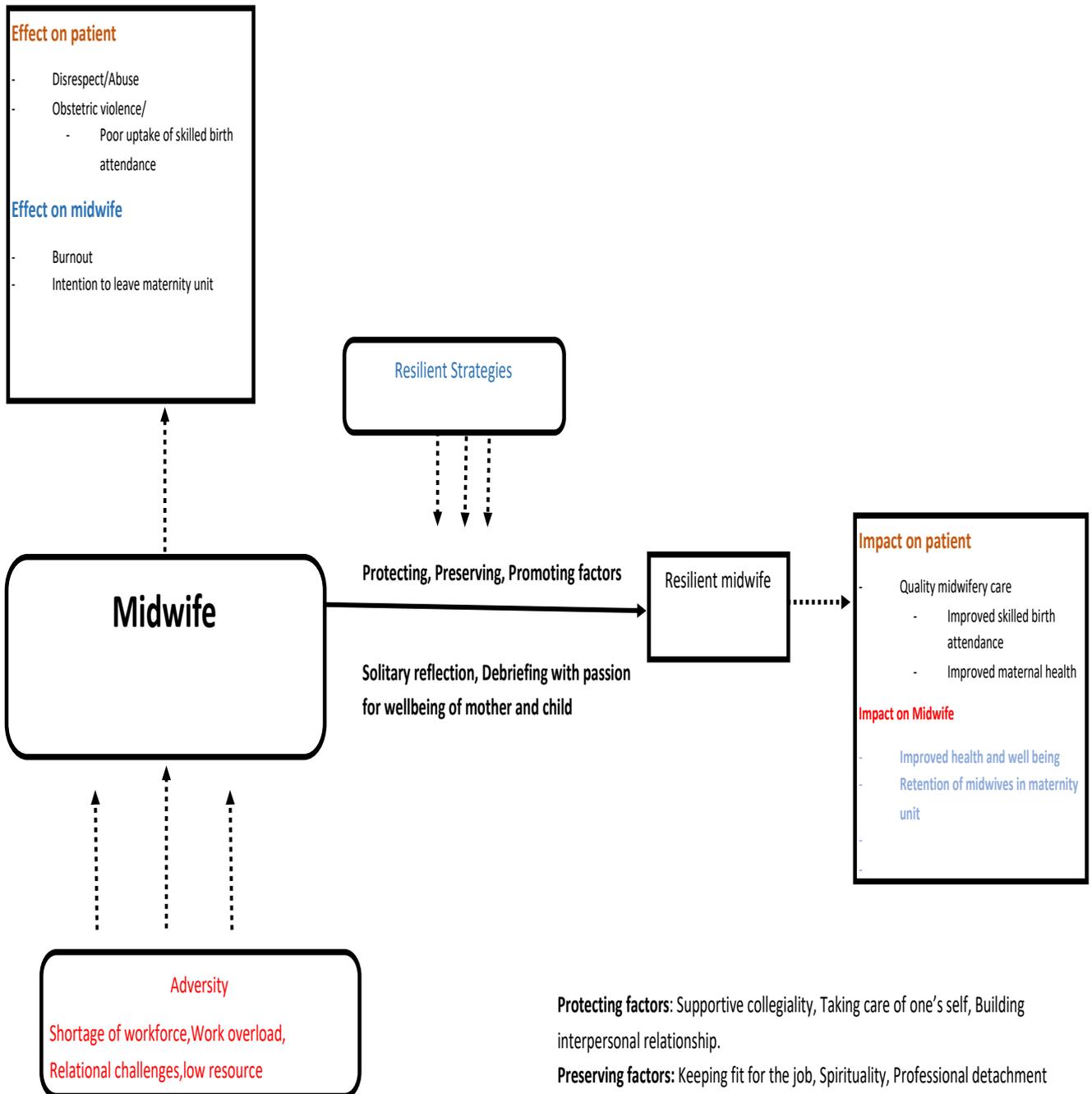
Appendix O: Dissemination

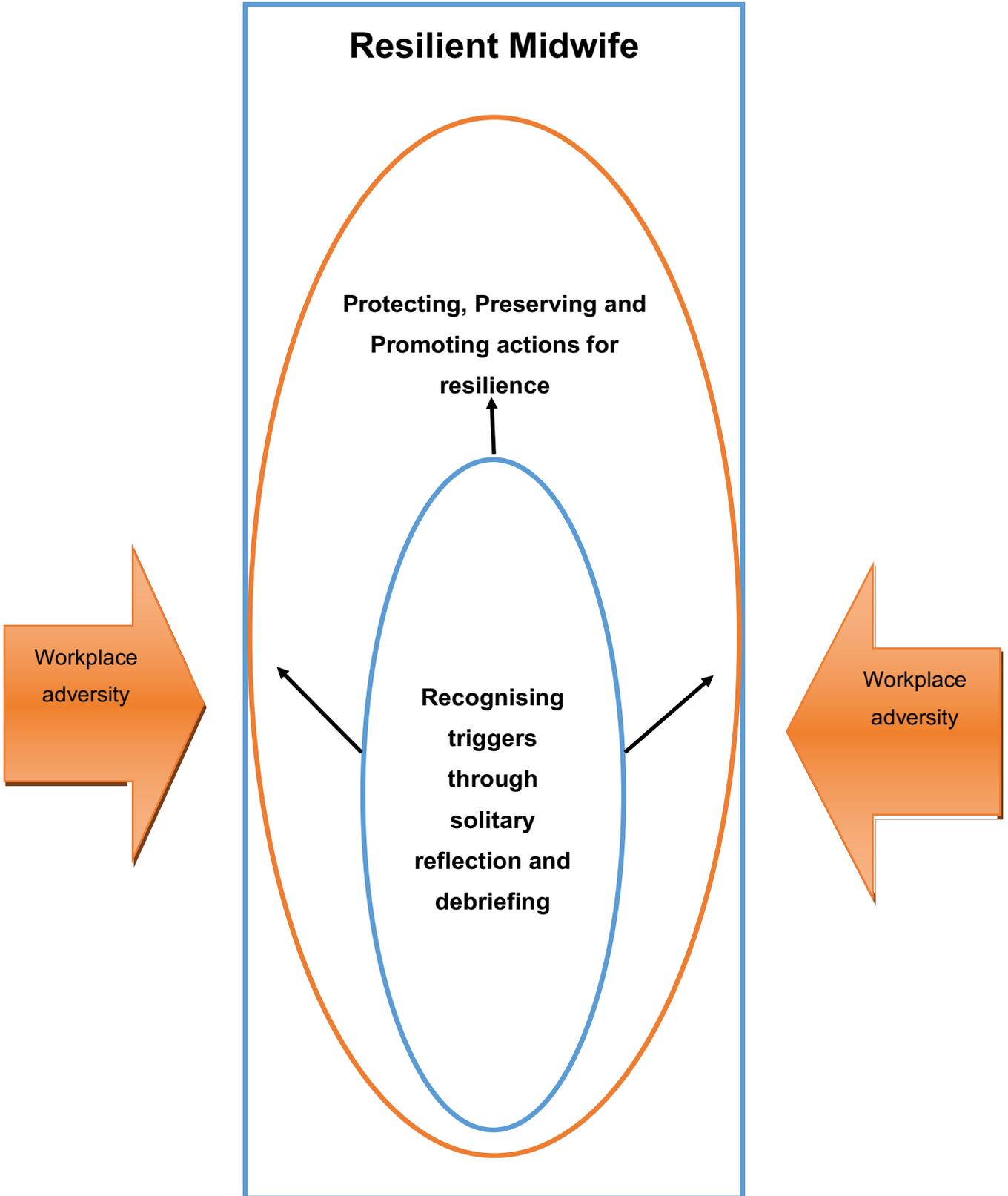
These included the following topics:

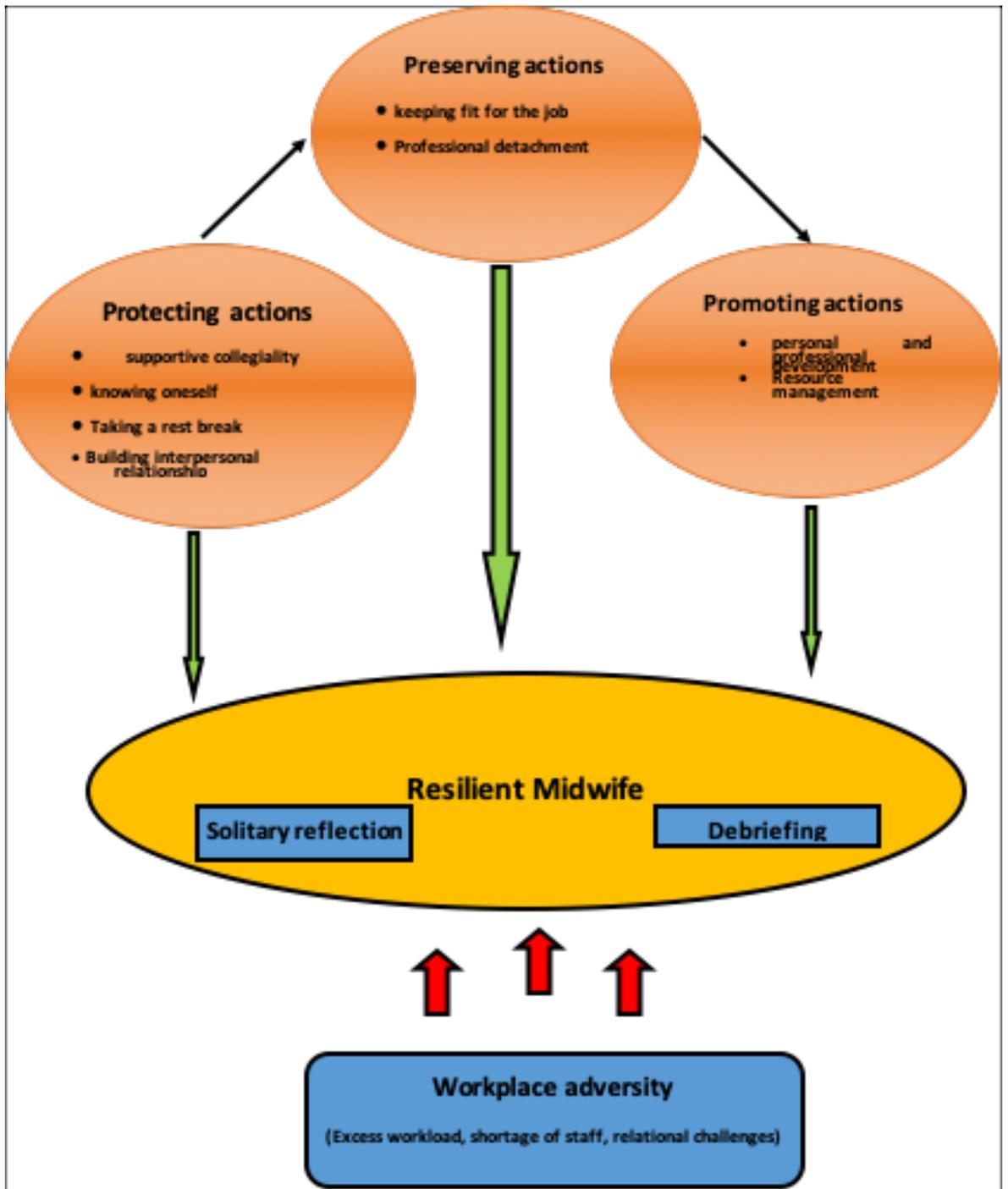
1. Why study resilience among Nigeria midwifery: a preliminary finding from a grounded theory approach; Presented at the 11th Virtual international day of the midwife conference: 5th May 2019
2. Can Understanding resilience among Nigerian Midwives enhance compassionate care? Preliminary report from a grounded theory approaches presented at the 1st international maternity expo awards and conference held in London, in June 2019.
3. Exploring workplace adversity among midwives in Nigeria: A study protocol presented at the post graduate research symposium held between 9th-10th Sept 2017 in Cardiff University.
4. Theoretical sampling and GT analysis: Presented at the Post graduate research symposium held between 9th and 10th April 2019 in Cardiff University.
5. *Even some of us were being slapped, and then what do you do? Is just at the expense of your job' ... Experiences and prevention of workplace violence among midwives in Tertiary Hospitals in Northern Nigeria: presented at 12th online Virtual International Day of the Midwife Conference*
6. Demystifying the constructivist grounded theory as a method of data collection and analysis in Nursing research: Presented 2nd Dec 2020 at 1st international conference and qualitative capacity building in Nigeria.
7. Exploring midwives' experiences of attending a traumatic birth in tertiary hospitals in Northern Nigeria: a grounded theory study: Accepted for a poster presentation for 32nd ICM Virtual Triennial Congress 2021

Appendix P: Diagram showing how my thinking evolved while developing my theory.

Finding Perspective: A Theory of Midwives' Workplace and Resilience







**Finding Perspective: A constructivist Grounded Theory on
Midwives' Workplace Adversity and Resilience**

