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Empowering Nurses to Improve Maternal Health Outcomes

Paper 1 from the Ethics, Payments, and Maternal Survival project

Paula Tibandebage, Tausi Kida,
Maureen Mackintosh and Joyce Ikingura

Working Paper
13/1

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Ethics, Payments, and Maternal Survival project - Paper 1

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Abstract

To what extent is the disempowerment of nurses/nurse midwives and other maternal health-care professionals an important factor contributing to poor performance in the provision of maternal health care, and therefore a contributory factor in poor maternal health outcomes? This paper addresses this question by using a systematic analysis of part of a data set from a research project *Ethics, payments, and maternal* survival. Drawing on concepts of empowerment from the nursing literature, we analyse qualitative data from interviews with staff in two hospitals and two health centres, and with women in sampled households who had sought maternal health care in the five years preceding the fieldwork in a single urban district in Tanzania.

We show that in the hospitals, staffing shortages were a key organisational constraint generating pressure on staff and contributing to poor behaviour towards women during delivery. In one of the hospitals, however, good management ensured a much better quality of care than in the other hospital. In two health centres, supply shortages were the main organisational constraint experienced by staff. In one health centre, staff morale, management and care were very poor, while in the other much more isolated setting, continuing relationships between the staff and community helped to reduce abusive behaviour towards women who were coming to deliver.

The lack of capacity for emergency care at the health-centre level, including transport for referrals, was a disempowering factor for nurses/nurse midwives in both health centres. As a way forward we consider the role of management in promoting an empowering environment for maternal health workers as key to improving the performance of available staff. Good management would involve, among other things, a system that values and promotes good professional behaviour while sanctioning bad behaviour, and promotes a more flexible, participatory and communicative system of management. Capacity building for both management and staff in this area would be required.

Acronyms

D&C	Dilation and Curettage
DG	Director General
EN	Enrolled Nurse
FBO	Faith-Based Organisation
MDG	Millennium Development Goal
MOHSW	Ministry of Health and Social Welfare
MSD	Medical Stores Department
Obs & Gynae	Obstetrics and Gynaecology
PPH	Post-Partum Haemorrhage
RN	Registered Nurse
TDHS	Tanzania Demographic and Health Survey
URT	United Republic of Tanzania
WEO	Ward Executive Officer
WHO	World Health Organisation

1 Introduction

With 2015, the target year for the Millennium Development Goals (MDGs) only three years away, Tanzania is still a long way from attaining its goal of reducing the Maternal Mortality Rate (MMR) to meet MDG 5. The MDG 5 target for Tanzania was to reduce MMR to 265 deaths per 100,000 live births. The Tanzania Demographic and Health Survey (TDHS 2010) estimates MMR during the ten-year period prior to the survey to be 454 deaths per 100,000 live births. This is lower than the 2004/05 estimate of 578 maternal deaths per 100,000 live births, but this figure was higher than the 1996 figure of 529 deaths per 100,000 live births (TDHS 1996, TDHS 2004/05, TDHS 2010).

There are numerous interlocking reasons for this policy failure. One such factor is the documented crisis of availability and performance of health workers in the health system as a whole (Mastad, 2006; Mastad and Mwisongo, 2011). This paper uses a systematic analysis of part of a data set from a research project *Ethics, payments, and maternal survival* to explore the extent to which the disempowerment of nurses/nurse midwives is a factor contributing to poor performance in the provision of maternal health care, and therefore a contributing factor in poor maternal health outcomes.

2 Theory and Method

This paper draws on two sets of literature: literature on empowerment of nurses and quality of care, and some of the large literature on the management and quality of maternal care. In this section we discuss some key aspects of these works and also briefly outline the fieldwork method of the project from which the findings are drawn.

2.1 Empowerment and the Management of Maternal Care

The work of nurses/nurse-midwives poses some specific challenges in the provision of maternal health care. Managing pregnancy requires close attention and obtaining and providing good information. The birth process is risky, and crises can arise rapidly and unexpectedly. As we document below, labour wards in hospitals are frequently very busy, highly pressured places. Midwives work autonomously for much of their working lives, at a highly responsible job that can involve pain and emotion.

An element of the nursing literature argues that empowerment of nurses is a valuable attribute that is essential to the effective functioning of a health care system (Palmier, 1998). Chandler (1986) was among the first to describe the process of empowerment in nursing. In her work (Chandler, 1992) she distinguished between power and empowerment, noting that empowerment enables one to act, whereas power connotes having control, influence, or domination over something or someone. Empowerment is a process through which power is acquired (Kerner, 1993). The argument thus implies that a lack of empowerment – a situation of frustration and constraint – undermines the ability of nurses to provide safe and good quality nursing care in order for the patients to achieve their maximum level of wellness (Manoijlovich, 2007). Empowerment has been viewed as having a potential role to play in professional development in nursing, and there is a substantial body of literature on the subject (Fletcher 2006, Bradbury-Jones 2007; Kuokkannen and Leino-Kilpi 2000).

Power, as Chandler's definition implies, is a complex attribute; control and influence may be used for good or ill. Hence, the empowerment of nurses must be within a context that not only enables nurses to do their job well in terms of delivery of good quality health care, but which also constrains the misuse of power. Such constraints may include management systems that penalise abusive behaviour and organisational cultures that value good performance.

The nursing literature draws on a variety of theoretical approaches to empowerment. The theory of *structural empowerment* proposes that organisational effectiveness requires opportunity and power in organisations to be available to all employees (Manojlovich, 2005a). Kanter (1993) argues that employees' work behaviour arises from conditions and situations in the workplace and not from personal attributes (Laschinger and Havens, 1996).

Degner (2005) argues that empowered employees are more committed to an organisation, more accountable for their work, and better able to fulfil job demands in an effective manner. Other studies have shown that structural empowerment contributes to job satisfaction (Manoijlovich, 2005b). Kanter's theory has been widely applied to the practice of professional nursing, showing how workplace structures that facilitate access to resources can empower nurses to accomplish their work in more meaningful ways (Kluska *et al* 2004; Siu *et al*. 2005). Other empowering factors identified in other studies include participative management, job enrichment, less bureaucracy, and involving staff in decision-making (Krawer and Schmalenberg, 1993).

Therefore, this theoretical perspective places the responsibility for the behaviour of an employee entirely on the organisation and its management. According to Kanter (1993), structural empowerment

is promoted in work environments that provide employees with access to information about the organisation, support in performing the job and in decision-making, the opportunity to learn and develop, and access to the resources needed by employees. Applying Kanter's theory, Hajbaghery *et al*. (2005), identified having authority, professional self-confidence in the application of knowledge and skills, and forms of collective power of nurses as important to empowerment. We explore our data for evidence – on a case study basis – that organisational and management support and facilitation of midwives in these ways are associated with positive patients' perceptions of maternal care.

A second theoretical approach, *psychological empowerment* moves the focus away from the organisation towards personal attributes, motivation, and psychological experience (Manoijlovich, 2007). Conger and Kanungo (1988) viewed empowerment as a motivational construct as well as a personal attribute. This perspective recognises that some individuals will try to do their job effectively even in disempowering environments. It sees individuals as being able to shape their work role. Spreitzer (1995) defines psychological empowerment as a motivational construct which is manifested in four cognitions: meaning, competence, self-determination, and impact. Meaning requires similarity between a nurse's beliefs, values, behaviour, and job requirements. Competence refers to confidence in one's abilities to perform the job. Self-determination refers to a feeling of control that is exerted over one's work. Finally, impact is a sense of being able to influence important organisational outcomes (Laschinger *et al*. 2001). Psychological empowerment therefore interacts with the characteristics of the work environment.

Meaning and values can be both rooted in and undermined by the culture of the organisation within which a nurse works. Furthermore, midwifery is a clinical field that links to deep-rooted emotions and the generation of human life. Teamwork and mutual support can be important elements of the job, and collaboration between midwives and the women they care for is important to patients' safety. We search our data for nurse midwives' sense of confidence, self-determination and impact, and their explanation of their feelings.

A third perspective, *Relational theory* seeks to understand empowerment in the nursing profession in relation to history and patriarchal structures within which nurses find themselves (Harden, 1996). It acknowledges the patriarchal nature of medicine and the health-care industry in general and the oppressive nature of the relationships it can generate (Chinn, 1995; Sampselle, 1990). Indeed, it has been argued that nurses are an oppressed group by class and gender perspectives (Lovell, 1982; Ford and Walsh, 1994). Drawing on liberal feminism, Wusef (1994) argues that an environment that promotes reciprocal professional relationships would be a more effective empowering environment for nurses. Fletcher (2006) sees relationships which can be built through dialogue and self-awareness as having the potential to break cycles of disempowerment for nurses.

This third theoretical perspective links values and organisational culture to nurses' historical experience of working relationships. Health care organisations are frequently hierarchical, devaluing teamwork among nurses and other non-medical clinicians. The literature on organisational culture in health care is inconclusive on the link between culture and performance (Scott *et al*. 2003; Davies *et al*. 2007). Yet the idea that culture influences performance has 'enduring intuitive appeal' (Scott *et al*. 2003:115). We explore our evidence for discussion of the relationships between midwives, supervisors, and doctors, and how these relationships are associated with institutional performance as perceived by patients.

Drawing from this set of theoretical frameworks, we use case studies of four health facilities to explore workplace and individual factors that may empower nurses/nurse midwives to deliver quality maternal health care, and those factors that may influence and sustain bad behaviour.

2.2 Project Methods

The sample and data collection instruments

Fieldwork for the project was undertaken in four districts located in two contrasting regions of Tanzania. In each region, the research included one urban and one rural district. Three wards in each district and then two streets or villages in each ward were chosen that displayed contrasting economic circumstances. Finally ten households were selected randomly along those streets or villages. Households where no woman was pregnant and/or no woman had given birth in the last five years were replaced. A total of 240 households were selected, sixty in each district.

Interviews with heads of households or their representatives in these 240 households collected basic data on the households' socio-economic conditions, while interviews with women collected data on payments and maternal care, including birth experiences. In the sampled households all eligible women were interviewed. In total, interviews were conducted with 248 women who had given birth in the last five years and/or were currently pregnant. The five-year cut-off point was applied to limit recall problems. The interviews captured information on the women's experiences of antenatal care, care at birth, and post-natal care, including payments made and their perceptions of the quality of care they received.

In addition, the fieldwork also included health care facility interviews that were conducted with health workers in 59 health care facilities in the selected districts. The health care facilities in the survey were at different levels and were drawn from three sectors – public, private, and those owned by faith-based organisations (FBOs). In total, 11 hospitals, 16 health centres, and 32 dispensaries were visited. Interviewees included medical directors and clinicians in-charge, managers responsible for maternal care, and midwives. Some traditional birth attendants were also interviewed.

Semi-structured questionnaires with provisions for in-depth probing were used in both household and health facility interviews. In addition, for household interviews a separate structured questionnaire was used to capture the households' socio-economic characteristics. Fieldwork was undertaken in September and October 2011. This paper uses interviews conducted at three public facilities and one non-profit facility in one of the urban districts.

Data analysis

Qualitative data on women's maternal health care experiences were coded and sorted into themes by using Nvivo software. Systematic analyses were carried out to identify patterns and commonalities and/or differences in experiences. Patton (2002) explains this method of qualitative data analysis in detail. Background data for health facilities and households were analysed with Stata software using descriptive methods such as graphs and cross tabulations. We triangulated data sources, e.g. responses from women and responses from maternal health workers, so as to identify similarities or divergences in their responses regarding issues of payment and what is considered ethical maternal care. We also triangulated quantitative data, e.g. on payments, with qualitative data to assess whether issues emerging from the qualitative interviews were consistent with the quantitative findings.

Ethical considerations

This study was undertaken with the approval of the National Health Research Ethics Review Committee. In conducting primary data collection and analysing the findings, efforts were made to ensure anonymity and objectivity. Respondents were informed about the objectives of the study, and their informed consent was obtained. Participants were assured of anonymity during the data analysis and in the presentation of the findings. Accordingly, data were coded to protect identities and ensure privacy.

Findings

In this section we examine four facilities in detail: two hospitals and two health centres. For each facility, we triangulate our evidence from: those in charge of facilities and maternity care; Nurse-midwives working in those facilities, and women who have given birth in the same facilities. We systematically compare the evidence for empowerment and disempowerment of nurses and midwives and the evidence of women's experiences of care while they were giving birth in those facilities.

3.1 A tale of two hospitals

We first compare two hospitals in the same city. Hospital A is an FBO-owned and run referral hospital. It charges formally for its maternal health-care services except for emergency admissions, and is attending a large number of deliveries, including self-referrals. Hospital B is a government-owned regional hospital. Like hospital A, hospital B also receives large numbers of women for delivery; many are referred by lower-level health facilities, others refer themselves or come after the lower-level facilities close; and others are women with pregnancy complications or emergency cases.

Two factors are common to both hospitals: first, staff shortages and resultant work pressure on nurses and midwives, and second, patients' complaints about staff rudeness.

3.1.1 Staff shortages and work pressure

In Hospital A, the major problem pointed out by all the staff interviewed was overwork in maternity wards due to shortage of nurse-midwives:

> "For maternity care you need staff, but we have a very high shortage of staff." **Nurse in-charge, maternity**

> "The staffing level is very small. We are so much overworked." **Nurse-Midwife**

One interviewee carefully explained the effect that such understaffing can have on the ability of nurses to ensure patients' safety:

> "Yes, there are serious staff shortages in maternity. Example of the labour ward: At night, the ward has 1 RN [registered nurse] and 2 ENs [enrolled nurses, from a shorter training course]. It is dangerously low. The ward needs five. Suppose, as usual, you have a caesarean section? A nurse has to go to the theatre with that patient. Then you have at any one moment, say, a delivery, one person waiting who needs monitoring, and one ante-natal admission. How should the two remaining people divide up? Who is organising the medications? It is not safe. And these are long shifts…" **Nurse manager, maternity**

In Hospital B, exactly the same core problem was mentioned by all the interviewed staff: a shortage of staff, and therefore overwork:

> "Here it is heavy duty – deliveries are at all times. We have two wards but staffing is basically for one ward." **Maternity in-charge**

> "It is hard to work in the maternity ward. In seven days we get only one day off. And this is when you have had a night shift. So we are so much overworked and exhausted."
> **Nurse midwife**

Data from these two hospitals show that both have staff shortages, but the situation appeared worse in Hospital B.

Hospital A, as a referral hospital for several regions, has two specialist obstetrics and gynaecology registrars per shift, plus consultants (eight in total) on call. The labour ward has seven delivery beds and there are seven admissions and 'waiting' beds for risky pregnancies. In addition, there are 45 post-natal beds. There are 25-30 deliveries a day. A high proportion of the maternity cases are referred emergencies, averaging around 30 in 24 hours, including obstructed labour, severe hypertension and eclampsia, Post-Partum Haemorrhage (PPH), post-natal complications and severe anaemia, caesarean section complications, puerperal sepsis, post-delivery eclampsia, and cardiomyopathy. The hospital has a total of 10 registered nurses and nine enrolled nurses with midwifery training assigned to the labour ward, plus other nursing staff for the post-natal ward which handled many emergencies; the nurse manager quoted above noted that the worst staff shortages for the labour ward occurred at night.

Hospital B is a regional hospital which for a long time has also been serving as a district hospital because there is no district hospital in the area. The hospital has only two obstetrics and gynaecologist consultants. The labour ward has 10 active labour beds and four delivery beds, 11 ante-natal beds, and 46 post-natal beds. There are about 40 deliveries a day on average, sometimes with women doubling up in beds. There are five to eight emergency cases a week. In total, the hospital has 23 qualified nurses working in maternity care, of whom only eight are registered nurses; the rest have lower levels of training. A morning shift typically has 8 eight nurses and a night shift has four, half of whom are in the labour ward.

3.1.2 Complaints about staff rudeness

Women who had given birth in both of these hospitals had some complaints about staff rudeness. Some women who described their experience of delivery at Hospital A complained of delays in being attended to, the use of abusive language, or nurses being rude:

> "The services were not good. I was not happy about the care I received during delivery at Hospital A. Labour pain started at home, uterine fluid started to run out, I took a taxi which rushed me to the hospital which I reached at five pm. After I arrived and in-patient charges were paid, then I was given a bed where I waited to deliver. At two thirty am my labour advanced too much. I called for a nurse several times, but no one came to help. I continued calling while struggling in bed up to three am when I delivered (alone) … This was dangerous for my life and my child's life." **Woman 23**

> "The nurses at the hospital are very harsh, especially when you seek advice from them; instead of responding politely, they will shout at you harshly. The attendants are few."
> **Woman 34**

Both the nurse in charge of maternity and the nurse-midwife recognised that the heavy workload could have a spill over effect:

> “Sometimes the nurses feel stressed and overworked, and this can have implications on the relationship with patients!” **Maternity in-charge**

There were many more such complaints by women who had given birth at Hospital B; this is an example:

> “They are so rude/harsh and do not have good hearts to help pregnant women who are really in need at the time of giving birth. They are harsh when attending pregnant women when they need help.” **Woman 13**

In each hospital there were also women who had not been subjected to abusive language. In Hospital B:

> “The doctors are experienced and do respect mothers; this is why most of us do return there.” **Woman 18**

> “The delivery service I got was good because I was never abused or shouted at during delivery.” **Woman 1**

Furthermore, some of the women interviewed did recognise the problem of the shortage of nurses in Hospital B. A woman who acknowledged that the quality of care she got was not good, and who regretted coming to deliver at the hospital after delivering alone and unaided in the ward, said:

> “What I learned from that experience is that the nurses are overwhelmed by work. The women who had come for delivery on that day were many compared to the number of nurses/service providers who were on duty.” **Woman 3**

The word ‘overwhelmed’ recurred in the data from both hospitals. There was an acknowledged interconnection between extreme pressure of work and the use of bad language by midwives. In Hospital A the nurse manager for maternity said that “A nurse cannot use abusive language, this is not professional”. However, she also pointed out that the shortages of staff on a hectic ward can be severe. “Nurses are human beings. When one midwife finds herself struggling with three difficult deliveries, then we need to give support, not just blame.”

In Hospital B the facility management also seemed to be aware of what was going on, and was sympathetic as to why such behaviour might be happening. The doctor in-charge said that in the context of the number of deliveries the nurses are trying to cope with and the level of complications:

> “You can’t blame the nurses … At the moment we deliver 40-70 cases (in 24 hours) with only three nurses (per shift); they will burn out.” **Facility in-charge**

However, there was no acknowledgement from the Hospital B management that this was nonetheless unacceptable behaviour.

At this point, the similarities between the evidence from the two hospitals end. Big differences appear in the data in terms of a number of key issues related to the empowerment of staff. These include differences in the availability of supplies for midwifery in the two hospitals; differences in management support for staff as expressed in incentives and technical support from medical staff; and differences in staff behaviour in terms of demands for informal payments.

3.1.3 Supply shortages and informal payments

The two issues of supplies availability and informal payments turned out to be closely linked in the patients' accounts. Many women told stories of being asked for informal payments in Hospital B and linked those accounts of bribery to delays and abuse by staff:

> "People who delivered at Hospital B say that they are poorly treated as follows: treated badly; nurses care for patients they know first; some mothers delivering while on the benches; mothers dying before attended by doctors." **Woman 1**

> "Services at Hospital B are poor ... If you do not have money they do not care for you, i.e. one patient delivered on the floor because she did not have money to bribe a nurse." **Woman 28**

> "I gave Tshs. 5000 to the nurse who assisted me during delivery. I gave it to her before the baby was born because I was scared and I was confused by the labour pains and the women in the labour ward who kept saying that if you give something to the nurse, at least you get someone to pay attention to you. So I did give money and I was given the services … Yes, it was much better than before I had given something or compared to the women who did not have anything to give. And there were very many women on that day." **Woman 37**

> "The service is not good at all, I was not satisfied with it because the attendants are after money; they do not attend patients with a clean heart; they do not care about the mothers.
> - They harass and abuse us.
> - They are corrupt.
> - You can only get supplies after giving gifts (corruption)

> "Actually the service I got from that attendant was because I paid for it; the amount I paid (Tshs. 4000) affected the kind of services I got, because if I had nothing, it means I would not have been attended." **Woman 40**

One woman had been treated well, but had seen the problems experienced by others:

> "I thank God that I received good care, although some of the nurses use abusive language, and if you do not have money to give a nurse or you do not have a nurse who knows you, you will get a lot of problems and they will not take care of you. They should give us good care; also there should be fair treatment between those who have and those who have not." **Woman 27**

Responses given by women who had sought delivery care at Hospital A were mixed but mostly positive, indicating that they had not been asked to make informal payments or to bring their own supplies:

> "The services I got at Hospital A during delivery were good even if I could not pay Tshs. 15,000; I am sure they would attend to me and I could pay after services." **Woman 1**

> "Even though I prepared myself and bought requirements like gloves, they were not used in the hospital. They used hospital supplies." **Woman 10**

One woman (Woman 12) said she was very pleased with the care she received while giving birth; she said the care was excellent because the birth attendant was present throughout and was ready to receive the baby after delivery. She said she would go to Hospital A for delivery again even if she did not have money. She said the amount she was charged was the same as in Hospital B, and nothing extra was paid for supplies or asked for as a gift.

Another woman contrasted this hospital with Hospital B:

> "The service is good; however, in my opinion Tsh. 10,000 for admission and in-patient care makes everyone able to go there. Even those with no money would be able to deliver at Hospital A. Here in this city we have a … hospital called B, but its services are very poor. You find a mother delivering herself at Hospital B; it is torture. Attendants do not care for patients." **Woman 35**

The facility staff at Hospital B said little about informal payments. The maternity in-charge admitted that women coming to deliver sometimes gave gifts, but insisted that she had not seen or heard of staff demanding anything from patients. However, a nurse-midwife admitted in general terms that asking for bribes was common:

> "Asking for bribes is a common problem even though the services are supposed to be free. Most of the women whom we assist to deliver give us thank you in monetary terms (which is not much). They give Tshs. 1000 to 5000 and give us *vitenge* (fabric), chicken, fish etc." **Nurse midwife**

At Hospital A the management claimed to be keen to take measures to sanction inappropriate behaviour such as corruption and mishandling of patients:

> "There is zero tolerance of theft. There is also zero tolerance of abusive language and bribery. Complaints are taken very seriously, and documentation and evidence sought. Theft and bribery can lead to sackings, and in the past they have. The older government employees can be sacked, not only hospital employees; it has happened. There has been no recent case of bribery found on the maternity wards." **Nurse manager, maternity**

> "…For midwives to ask for money, this is not common. It is not a practice, and the management is very firm on this." **Nurse midwife**

The women's evidence supports these claims.

In both hospitals the data regarding essential supplies showed that many of the required supplies were available within the facility. Interviewees in the health facilities were asked about the current availability of six essentials for handling normal in-patient delivery and 15 requirements for assisted delivery and emergencies[1]. The staff in Hospital A stated that they had all of these. The Hospital B

1 The list was compiled on the basis of expert advice. The six normal delivery essentials were: clean latex or sterile gloves; disinfecting solution; delivery bed; scissors or blade; cord clamp or tie; suction apparatus (bulb or machine). The emergency requirements were: syringes and needles; sutures; intravenous solution and perfusion set; injectable oxytocic medication; oral valium or magnesium sulphate; injectable valium or magnesium sulphate; injectable antibiotic or gentamicin; injectable hydralazine; injectable ergometrine or methergine or misoprostol; vacuum extractor for assisted labour; vacuum aspirator or D&C kit; blood transfusion capabilities; capability for caesarean section; capable MO available/on call; anaesthetist/nurse-anaesthetist available/on call.

staff said they lacked oral valium or magnesium sulphate, a vacuum extractor for assisted labour, a vacuum aspirator, and a Dilation and Curettage (D&C) kit, and they were unable to say whether an injectable antibiotic was available on the day of the interview; the other items were all available.

In Hospital A, the qualitative evidence from staff supported the availability of all essential supplies, with a commitment that started at the top:

> "The DG is a gynaecologist and is always arguing for women. If you run out of something, he wants to know why it wasn't ordered well in advance! ... If you don't make a good estimate, for enough gloves for example, it is your fault … If you don't have the right supplies, you have to go to the administration and explain why." **Nurse manager, maternity**

> "Supplies are there, no problem." **Nurse in-charge, maternity**

The women's interviews also supported this claim; there were no complaints about missing supplies:

> "Even though I prepared myself and bought requirements like gloves, they were not used in the hospital. They used hospital supplies." **Woman 10**

> "The service was good. All the requirements were available – for instance, I was told by nurses during ANC to prepare myself with four pairs of gloves, threads, and mackintosh, but all were not used. They used the hospital supplies." **Woman 26**

In Hospital B the facility in-charge also did not identify severe problems in terms of the availability of medicines and other medical supplies. They were using cost-sharing money to fill in gaps arising from major shortages in the Medical Stores Department (MSD). "People are pushed here by lack of supplies elsewhere," he said. A nurse midwife differed in her opinion; it was the shortage of staff that received most emphasis from her:

> "To work in [this] hospital labour ward is a hard job; this is mainly because we have a shortage of staff and we do not have adequate supplies." **Nurse midwife**

> "When we run short of supplies, e.g. gauze, then delivery procedure is a problem, or when we run short of cord ties then we have to do it in an unprofessional way, and over-bleeding can occur." **Nurse midwife**

The women interviewed also differed in their experiences of the availability of supplies, and there seems to have been some link between informal payments and access to supplies, as suggested by a quotation above. One woman said that she had bought syringes and gloves from the pharmacy for the nurse midwives to use at the time of delivery, because the supplies "are not available in the hospital" (Woman 13). However, others said:

> "Medical health supplies and medicine are available at the facility." **Woman 36**

> "I did not buy supplies; everything was available at the hospital." **Woman 16**

3.1.4 Support and incentives for midwives

As experienced by the patients, the weight of evidence shows that Hospital A is achieving a higher quality of care when compared to Hospital B. What makes the difference? The literature reviewed would suggest that support for staff may be a differentiating factor, and we asked nurse midwives about the support they received and questioned all interviewees about the incentives for the staff.

In Hospital A it was clear that the management was supportive of staff who, despite constraints of overwork due to shortages of nurse midwives, nonetheless felt valued and supported in doing their job:

> "Supervision/administration is facilitating, even if you go there to report a shortage of supplies they do their best to assist". **Nurse in-charge, maternity**

> "The hospital recognises and values the work I do." **Nurse midwife**

> "The relationship between health workers is generally good and we work as a team." **Nurse midwife**

We asked about medical back-up when required:

> "The technical support system is very efficient; on any shift there is an intern (first on call), a resident (second on call), and a specialist (third on call)." **Nurse midwife**

In Hospital B it was evident that staff working in the labour ward felt that the management was not being very supportive:

> "Even if you complain about shortages, management does not seem to see this as a problem. Generally, management does not seem to recognise and appreciate the work nurses do, and so sometimes nursing and midwifery are not given the required priority." **Maternity in-charge**

> "Another challenging task is the relationship between midwives and doctors on call. Doctors who are on call are not available most of the time. I cannot explain the reasons for the doctors not to be available. We have two doctors (specialist Obs & Gynae), but when we have emergencies they are most of the time not available." **Nurse midwife**

> "It is very hard to get technical support from the medical doctors; last year was worse; at least now we have two new ones, but it is a common phenomenon for us when seeking technical help for a medical doctor not to be around for unexplained reasons." **Nurse midwife**

However, the facility in-charge reported that there were currently two medical specialists including himself, and that they had to do six to eight caesareans a day.

We also asked about incentives, in the sense of financial and practical support for staff. In Hospital A the salaries of many hospital staff were paid by the government, and there were complaints about salary delays, low salaries, and non-payment of allowances. Still, the hospital management was making efforts to provide some incentives:

> “Of the private patients’ payments, a percentage goes for incentives to staff. The rest goes to a basket fund for supplies.” **Nurse manager, maternity**

> “The government is not giving any allowance, but Hospital A is giving some allowances to the staff in maternity just to motivate them.” **Nurse in-charge, maternity**

> “They pick us up when we are coming to work, and they provide us with tea, which is very helpful**.” Nurse midwife**

In Hospital B the facility in-charge said that he was trying to provide minimal incentives for nurses, such as tea and bread. He said that a flat-rate extra duty allowance was paid to the staff, but there was a lack of funds for other incentives. The block grant could be used, but that had just been cut by 30 per cent. He recognised that:

> “The nurses need support, mentally and physically; they can’t work around the clock.” **Facility in-charge**

> According to a nurse midwife:

> “We work in a very difficult environment; we do not have any kind of incentives. We do not have night allowances; even extra duties allowance is not paid.” **Midwife.**

3.1.5 Reputations and Interactions

Some women interviewed compared the two hospitals and explained their choice between them. The conditions at each hospital, and their reputation, influenced both their own and the others’ demands for services, as did conditions at the lower-level facilities. Both hospitals received women who chose to go there, women for whom it was the only choice when lower-level facilities failed them, women referred as emergencies, and – in the case of Hospital A – private patients.

In Hospital A staff recognised that women chose to deliver there in order to avoid Hospital B. The hospital director expressed frustration:

> “I cannot tell Hospital B what to do. Women say ‘why should I go to Hospital B and die?’.” **Facility in-charge**

The nurse manager explained:

> “There are several different types of admissions. There are large numbers of referrals. Some people self-refer; they say they don’t like Hospital B.” **Nurse manager, maternity**

One woman interviewed had decided to go to Hospital A for delivery because she did not trust the services offered at Hospital B. She delivered at Hospital A despite being referred to deliver at Hospital B. She had changed her mind because she did not trust Hospital B, particularly bearing in mind that she was living with HIV. She said that at Hospital B the nurses were not careful enough, and she feared that her child could get HIV if she had to deliver at that facility. It was better, she said, “to pay in order to secure the life of my child” (**Woman 12).**

However, there were women who said they received good maternity services at Hospital B, citing cheap or free services and the experienced staff:

> "I chose to deliver at Hospital B because their services are good, less expensive, and in case of emergency, one could get all such services there." **Woman 14**

3.2 Two Government Health Centres

In this section we compare and contrast two government health centres. Health Centre C is in an urbanised area of a city, while Health Centre D is located in the most remote part of the municipality, where the social and physical environment is basically rural. Both faced some very similar constraints, to which they were responding in distinctive ways.

Neither health centre – unlike the two hospitals – was facing a severe staffing constraint. There was a real effort by the government to improve health centre staffing in 2011, and both health centres had received new staff. The in-charge at Health Centre C was very pleased to have gained new personnel, with the health centre being well staffed as a result; there were two assistant medical officers, eight clinical officers, and 11 nurses, of whom three were doing midwifery. Health Centre D also seemed reasonably satisfied with its staffing level; there were three clinical officers and six nurses, including one RN and two other nurse midwives. Three nurses did midwifery and all did ante-natal care. Neither health centre had a theatre, so they could not do caesarean sections, and nor did they have blood bank facilities.

3.2.1 A crisis of supplies

However, both health centres were facing recurrent supply shortages in terms of assets for maternal care. Of the six requirements for normal delivery (see footnote 1), Health Centre C stated that they had no gloves and no suction apparatus, although Health Centre D stated that all these were available at the time of the visit. Of the 11 requirements for dealing with emergencies that could be used at a health centre without a theatre or blood bank[2], When visited, Health Centre C had *only* sutures and intravenous solution from this list. Health Centre D had six items; the missing items were sutures, oral valium or magnesium sulphate, injectable hydralazine, a vacuum extractor for assisted labour, a vacuum aspirator, and a D&C kit.

According to the facility in-charge at Health Centre C, the lack of supplies was a severe problem. The last supply of medicines to the facility had been in mid-May 2012, which was about four months before our visit in September. There were repeated stock outs of essential medicines and supplies for maternity, such as surgical gloves, delivery kits, and oxytocin. Supply was irregular, and often they did not get sufficient quantities of what they had ordered.

Supply shortages made it difficult for Health Centre C to handle complications they would otherwise have been able to deal with, such as Post Partum Haemorrhage (PPH). Therefore, women who came to deliver were told to bring supplies such as gloves and even oxcytocin. The facility had no ambulance of its own, and the service from the only ambulance serving all facilities in the city was not reliable. Hence, referred emergency patients had to pay for transport from the health centre to

2 Syringes and needles; sutures; intravenous solution and perfusion set; injectable oxytocic medication; oral valium or magnesium sulphate; injectable valium or magnesium sulphate; injectable antibiotic or gentamicin; injectable hydralazine; injectable ergometrine or methergine or misoprostol; vacuum extractor for assisted labour; vacuum aspirator or D&C kit; blood transfusion capabilities.

hospital. The health centre referred women largely to Hospital B, but also to Hospital A for more complicated cases.

When asked what happened if women were unable to pay for transport, the in-charge said:

> "If a referral patient needs to pay for transport and does not have money then she will have to wait until the ambulance from the city arrives. Even if she is bleeding there is no way. She will have to wait." **Facility in-charge**

The problem of supply shortages was also pointed out by both the nurse in charge of maternal services and the midwife. The nurse in charge of maternal services, who put the number of deliveries they handled per month at between 48 and 52, said:

> "The main challenge is shortage of supplies, which makes it hard sometimes to do our jobs effectively. The main issue is shortage of gloves, antiseptic. Sterilisation process is also poor; we are using boiling methods using kerosene equipment. The electrical steriliser is not working properly … The main disincentive to midwives is the shortage of supplies and sterilisation equipment." **Nurse in-charge, maternity**

The nurse in charge of maternity at Health Centre C felt she had little influence on the availability of supplies:

> "As an in-charge I do not have much influence to ensure availability of the key supplies. We report almost every day in our morning reports but my influence is limited." **Nurse in-charge, maternity**

A midwife also confirmed the severe shortage of supplies, saying patients were asked to bring supplies such as gloves, oxytocin, syringes, and sometimes infusion solution. The midwife said the shortage of supplies was putting them at risk. She said their job had become risky since the 1980s, especially with the prevalence of HIV:

> "If there are no essential supplies you are worried because you could be at risk and also you do not have peace of mind. As midwives we should try to cope with the situation and do our job since this is a job that requires one to have a calling. However, we should push for improvements to be made in making more resources available." **Nurse midwife**

This midwife said that if she was younger and had the opportunity to change jobs, she would do so.

Health Centre D also experienced recurrent supply shortages. In particular, a shortage of gloves was said to be a critical problem. The in-charge said they often experienced delays in receiving supplies, and the MSD did not bring what was ordered:

> "They might bring more supplies of items that we do not need and bring less of those we need most. For example, they might bring only one box of gloves (fifty pairs) and expect it to last for three months. The last time we received supplies was in May; this is September." **Facility in-charge**

The nurse midwife also pointed out that the glove shortage was a crisis:

> "No single pair of gloves has been received in kit in the last six months, while we have an average of between 30-50 deliveries per month. Usually a kit comes with only one box of 50 pairs of gloves for three months. The gloves issue is a crisis. One woman can use an average of up to three pairs of gloves. They last only one week. So we are compelled to ask them to bring gloves because it is risky to handle without protection. Ergometrine is also not sufficient for the cases of PPH. Only one or two boxes in a kit is not sufficient." **Nurse midwife**

Asked about the ordering system, the nurse midwife said yes, they do order things themselves, but what is put in the kit is often quite different from what was ordered.

3.2.2 Bribery and abuse

In both health centres women confirmed that there was a lack of supplies, and they often linked this to demands for money and abusive behaviour.

Few women indicated that they had gone to deliver at Health Centre C. Those who had done so expressed dissatisfaction with the services they received, and often associated bad services with not being able to give money to staff:

> "No, in government hospitals I never got services ethically. The nurses are abusive/ insulting and chase women away. For instance, at Health Centre C I was told, 'don't come back here you are disturbing us, you got pregnant out of your own pleasure … come back after two months'." **Woman 10**

One woman had been referred to Hospital B by Health Centre C on the grounds that the health centre had no gloves. However, she thought that the referral was actually because she did not give money to staff:

> "I was not asked to pay anything, but this might have contributed to the refusal at Health Centre C." **Woman 16**

Furthermore, this woman compared the quality of service at the health centre during her most recent delivery in 2010 with that during her preceding delivery, saying that services were good back then and medicines and supplies were available.

When asked about bribery, the facility in-charge at Health Centre C said that it did not occur. However, she went on to say that such practices were difficult to prove, giving the impression that nothing could be done to control the problem:

> "This happens but it is hard to have evidence for it. It is also common for patients to give thank yous. You have no control over this. Someone has given out willingly." **Facility in-charge**

A nurse midwife at the same health centre acknowledged that women sometimes give them gifts, but went on to say that this did not make them treat those who gave gifts better than those who did not. "After all, they give gifts after getting services," she said. However, one of the women interviewed said she gave a gift of Tshs. 2000 in thanks, so that she would get a good service the next time she comes.

In the case of Health Centre D, women confirmed that they had encountered the problem of inadequate supplies:

> "The services at Health Centre D are not good, because they lack some important services for pregnant women, something which is dangerous to us. For example, I did not get folic acid for blood anaemia, a blood pressure test, tests for dizziness, until I was directed to get those services at [a government dispensary]. So I request the government to work on that and make sure that the mentioned services are available at [Health Centre D]. At the facility, even the water for cleaning is a problem. Gloves are also a problem ... In 2006, in my first delivery, the bleeding was so heavy and you can imagine – the facility had no injection for that, until it stopped by itself. It is a problem." **Woman 42**

> "Also the water for cleaning is a problem; the patients have to walk to the nearby source … To me, all I saw was chaos." **Woman 43**

> "It is a very difficult time when one wants to go for a delivery service because everything, all supplies and medicines, you need to buy, and for me, I really could not afford it until I had to borrow some cash from my friends." **Woman 45**

Giving her opinion at the end of the interview, one woman said:

> "I think there is a shortage of supplies because everyone who goes for delivery is requested to buy supplies, especially gloves, so the government should take necessary measures for this." **Woman 50**

However, while payments for supplies seemed universal at this health centre, not all women at Health Centre D had experienced abusive language or bribery. The same woman said:

> "I was lucky to get a nurse with polite language to help me through delivery." **Woman 50**

On the issue of bribes, the in-charge at Health Centre D acknowledged the problem, but like the in-charge in Health Centre C, he said it was done in a very secretive way and it was therefore hard to get evidence. There was no indication of measures being taken to address this problem. The nurse midwife seemed uneasy about commenting on the issue but she did indicate that sometimes women give 'something' as thanks for being attended well. She gave examples:

> "Women can sometimes bring you fish, sweet potatoes, or vegetables. So for us who are in a rural setting, women are very friendly; they are always bringing something." **Nurse midwife**

However, only two women said they had to make informal payments to nurses at Health Centre D, and they took this as a condition for getting good care:

> "The nurse also told me to give her 5000 shillings, the amount which was said to be for kerosene. I offered this after delivery. Each woman who delivers there has to contribute 5000 shillings though they say it is for kerosene, but we know it is like a gift, because even those who go and deliver during the day contribute the same." **Woman 56**

> “The midwife who we found during the afternoon was so rude, but the one who helped me to deliver was so kind and polite and she took good care of me. But the problem was the money I paid, but it helped me. If I did not have money they would not help me.” **Woman 63**

A few more women said the nurses at Health Centre D were rude and harsh without relating this to informal payments. Most of the women who said they received good care knew someone at the health facility, or said that their husband was well known locally, and they attributed their good care to this:

> “I went to Health Centre D because it is near my home. I believe that Health Centre D does not provide a good service, but because I know someone there (the in-charge), that is why I went to that facility. Also because they took good care of me … The service I received was ethical because I was attended by people who already knew me and some were my tribe mates.” **Woman 47**

> “Actually Health Centre D is near my home, but again that is not enough, because the doctor of the facility (Dr. XY) and I are good friends. Thus, I always opt to go to Health Centre D for services. So to me, as long as I know someone in the facility, I will always get good treatment. I also know one nurse at the facility who is my friend, she is called ...i, who is really a friend to me and she is always helping me once I go there for service.” **Woman 44**

In this rural location, personal relationships strongly affected the behaviour between staff and patients.

3.2.3 Disincentives and staff morale

Staff in both health centres complained about the conditions of work. In Health Centre D the nurse midwife explained how poor and inadequate the infrastructure is:

> “Work conditions are not good. The labour ward is too small and has no partition. We are doing manual vacuum aspiration (MVA) using a screen which has to be borrowed from the doctor in-charge’s office.” **Nurse Midwife**

Summarising all this as one of the disincentives in her working life, a nurse midwife in Health Centre D said:

> “No support and supplies. This is frustrating for me since I am unable to do my job well. The situation can be stressful as you are often feeling helpless.” **Nurse Midwife**

In Health Centre C there seemed to be little initiative by facility management to promote staff motivation, which is an important factor in job performance. Asked whether there were incentives for staff, the facility in-charge said there were none. The facility had budgeted for small incentives such as tea for staff, but they had not received the budgeted money. The in-charge expressed frustration, saying:

> “It is hard to cope as an in-charge in this situation and continue to encourage the staff.” **Facility in-charge**

The nurse in-charge also felt that the promotion system was unclear and reported this as a demotivating factor for staff.

Staff at Health Centre D found the remote location challenging. The rural setting created additional constraints for staff, including very poor housing conditions and associated acts of robbery in staff houses, as well as beliefs and practices of witchcraft:

> "This is a hard area to work. There is a widespread belief in witchcraft, and robbery. Most health workers prefer not to work here. We do not have enough security and the municipality does not pay for it. The ward level has not enough money to finance this service. We need to enhance our security. We cannot use our user fee fund for this as it is not enough. We only collect about 300,000 per year from user fees." **Facility in-charge**

The facility was not providing any incentives to the staff. The in-charge said he could only try to live by example and encourage the staff, because this was a hard place to work. Members of staff were not getting any allowances, including hardship allowance, and new staff had not been paid the settling-in allowance to which they were entitled. A nurse midwife gave examples of the severity of the problem of not getting allowances and other entitlements:

> "No monetary incentives, e.g. no longer being paid overtime. This is the third year it has not been paid. There are new recruits who have not even been paid subsistence allowance. They are still staying in town. When you want to go on leave, no travel allowance is paid. There is no promotion – I was last promoted in 2004. Our facility in-charge was last promoted in 1999." **Nurse midwife**

Regarding the channels of communication between management and staff, Health Centre D seemed to have more staff meetings – at least once a week, compared with Health Centre C where the facility in-charge indicated quarterly meetings. The midwife at Health Centre D said that they received help and support from the in-charge when needed, noting that this was especially true since the arrival of two more clinical officers, giving the facility three in total.

The demoralisation and lack of supplies and infrastructure were causing considerable dangers to women delivering at the health centres. Health Centre C encouraged women to deliver at Hospital B, and Health Centre D was referring complicated and emergency maternal cases to Hospital B. However, both health centres faced transport problems. At Health Centre D the lack of transport for referred women was compounded by the remoteness of the location. In the case of Health Centre C, we have already quoted the in-charge as saying that women who were bleeding would be left to wait for long periods for transport, and many women did not have money to pay for transport.

Since neither health centre – indeed, no local government health centre in this district – had a theatre therefore no capability to undertake emergency surgery, this transport problem could be fatal and also frustrating for some of the staff. For example, at Health Centre D:

> "One day a woman in her seventh pregnancy arrived at the facility in prolonged labour. She arrived at ten pm. The phone network was very poor, the women had no contractions. We called WEO but the vehicle had no fuel, and the ambulance we use comes from another centre. In the struggle to get help the woman finally died before a police escort could arrive. Her husband was out in the lake fishing and she had two young children in the house." **Nurse midwife**

4 Discussion

The overall findings of this study show a close interaction between problems of staffing and supplies, and those of morale and staff behaviour and performance. In hospitals shortage of staff, which was causing the few available staff to be overworked, seems to be the key organisational form of disempowerment; while in the health centres it was supply shortages. However, it is clear from the findings that while overwork contributed to unprofessional behaviour, such as the use of abusive language towards patients, in all four health facilities, and particularly in the hospitals where staff shortages were more serious, Hospital A was achieving a higher quality of care as experienced by the patients. This, the findings suggest, can be largely attributed to a system of management that values and promotes good professional behaviour by enforcing sanctions against inappropriate behaviour. The clear zero tolerance position regarding bribery practices in Hospital A is a case in point. Indeed, it has been argued that while autonomy facilitates empowerment of professionals, tight rules and procedures are part of a well-balanced management approach to improving the performance of health workers (Marchal *et al*. 2010).

Our results also show how severely the shortage of supplies affected staff performance in the two health centres. Implications of the shortage of drugs and essential medical supplies for the quality of maternal health care have been clearly expressed by both maternity health workers and women who were seeking maternity health care. This has also been underscored in other studies. For example, in a study by Mathauer and Imloff (2006), health workers indicated that as much as they would have liked to have higher salaries, what they wanted most was the availability of the means and materials to enable them to perform well professionally.

Furthermore, an absence of incentives was shown to constrain both hospitals and health centres, affecting staff morale and therefore performance. It is worth noting that non-monetary incentives, such as promotion and career advancement, are among the factors that affected the morale of the midwives. Other studies also show that non-monetary incentives, such as professional development, appreciation of managers and colleagues, and recognition, are important factors that affect health workers' performance (Mathauer and Imloff, 2006; Dieleman *et al*. 2003; Dieleman and Hammeijer, 2008).

Our findings also indicate the importance of support and effective communication across facility hierarchies. It was clear from the responses of midwives and maternity in-charge in the four health facilities that staff morale and appreciation of management were better in Hospital A, where there was real evidence of staff support and where there seemed to be better communication across hierarchy levels (relational empowerment). On the other hand, the fact that midwives and the maternity in-charge at Hospital B did not know where to locate the doctors on call in that facility shows how an ineffective hierarchical system can be disempowering to nurses.

Finally, our results show how resigning themselves or giving up (psychological disempowerment) and not trying to do their best in the given circumstances can worsen the situation. In Hospital B and Health Centre C some staff seemed to have given up on trying to work well. A resigned attitude was clearly portrayed by the in-charge at Health Centre C. This inhibits processes through which alternative ways of coping with the situation can be identified. Indeed, such a resigned attitude on the part of the in-charge in Health Centre C could be a reason why morale seemed to be lowest among the staff in that facility.

5 Conclusion and Implications for Policy and Practice

This paper has drawn on data from an exploratory study to examine factors that are disempowering to nurses and nurse midwives. The motivation for exploring these factors was the persistently high level of MMR in Tanzania, which is partly attributed to poor-quality maternal care in health facilities. Maternal health workers often bear the brunt of complaints from women seeking maternal health care about poor quality-services and patient handling.

Drawing on concepts of empowerment from the nursing literature, we have attempted to explore the extent to which disempowerment of nurse midwives and other maternal health-care professionals is an important factor contributing to poor performance in the provision of maternal health care, and therefore a contributory factor in poor maternal health outcomes.

We have shown how the absence of key empowering factors can contribute to the disempowerment of maternal health workers. These range from factors related to organisational forms of disempowerment, such as shortages of staff and supplies, poor infrastructure, and poor working environments, to those that are generated and sustained by the system of hierarchy within which health care is provided. The role of management in promoting an empowering environment for maternal health workers cannot be over-emphasised. The following may be considered as measures that might contribute to overcoming elements that disempower maternal health workers, in order to enable them to play a more effective role in contributing to better maternal health outcomes.

- Provide short-term management training to those in charge of health facilities as well as other health facility staff to impart knowledge and skills about supportive and participatory management. This will enhance the capacity of health facilities to put in place more participatory and communicative management systems and more flexible and interactive management hierarchies.

- It is clear that the absence of incentives affects staff morale. Some of these incentives are non-monetary, and health facility management should commit to promoting these even if financial resources are a constraint.

- The problem of health-worker shortages is acknowledged at the national level, and measures are being taken to address it. However, there is a clear need to rethink how the currently available qualified staff may be empowered to improve performance.

- The severity of supply shortages, especially in lower-level facilities, and its apparent interaction with acts of bribery and abuse of patients, raises questions as to whether such shortages are artificially created. The underlying causes of such severe supply shortages need to be investigated by looking into issues of disbursed funds, bureaucratic procedures in the disbursement of funds, delays in placing and receiving orders, supply leakages, etc.

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