

The challenges facing nurse-midwives in working towards Safe Motherhood in Malawi

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A midwife is the only health worker most of the women of the childbearing group in Malawi will ever meet in their lifetime. A midwife plays an essential role in the promotion of health and provision of care to these women. It is therefore,

very important that midwives be available for the well being of these women. However, mere presence of midwives is not adequate for women's optimal health.

Introduction

In Malawi, being pregnant is a great threat to the woman's life. A significant number of pregnant women die or either lose the babies or sustain long-term morbidity. A vicious cycle of repeated pregnancies is likely to occur because those women who lose babies keep on trying to have a live baby hence increasing their chances of dying. This is largely because in Malawi bearing children is still considered as a primary purpose of marriage. While there are 27 maternal deaths for every 100 000 live deliveries in developed countries, in developing countries the ratio is 480 maternal deaths for every 100 000 live births (NGO Networks for Health, 2000). In Malawi, the figure stands at 1120 deaths for every 100 000 live births (National Statistics Office of Malawi, 2001).

One decade after the launch of the Malawi Safe Motherhood Program, maternal and neonatal mortality ratios remain tragically high. The maternal mortality ratio almost doubled from 620 to 1120 per 100 000 live births and the neonatal mortality rate stands at 42 per 1000 live births (National Statistics Office of Malawi, 2001). Several factors have played a role in these poor health indicators. The major factors are the HIV/AIDS pandemic, shortage of midwives, inadequate resources in the hospitals, and gender inequalities and traditional practices. In this paper, the authors present these factors as challenges facing nurse-midwives in working towards safe motherhood in Malawi and some recommendations in an attempt to solve the identified challenges.

The Challenges

The HIV/AIDS Pandemic

Malawi is one of the sub-Saharan African countries that are severely hit by the HIV/AIDS pandemic. Currently, the prevalence rate of HIV/AIDS infection in Malawi is at 14.4% in the reproductive age group of 15-49 years (National AIDS Commission, 2004). In women attending antenatal clinics, the national prevalence rate is at 19.8% (National AIDS Commission, 2003). The dramatic rise in maternal mortality ratio from 620 (Demographic and Health Survey, 1992) to 1120 (Malawi Demographic and Health Survey, 2000) might be to an extent, a sequel of the HIV/AIDS pandemic. This speculation comes, especially when one looks at the trend in the change of the major causes of maternal deaths in the southern region of Malawi. Nationally, sepsis was responsible for the 20% of direct obstetric maternal deaths in the late 80s. It is now responsible for 32% of direct obstetric maternal deaths in the southern region of Malawi and has overtaken haemorrhage (Ratsma, 2001). According to the Malawi Demographic and Health Survey (2000), one of the possible explanations for the high maternal mortality ratio of 1120 per 100 000 live births is that 'the HIV-infection-induced immuno-suppression may have caused

increases in case fatality from pregnancy and delivery related infections'. It is a common occurrence these days to see pregnant women who are also chronically ill. Such women are likely to have unfavourable pregnancy outcomes.

Shortage of Nurse-Midwives

The single most critical intervention for safe motherhood is to ensure that a skilled attendant is present at every birth (NGO Networks for Health, 2000). A midwife is the only health worker most of the women of the childbearing group in Malawi will ever meet in their lifetime. It is therefore, very important that midwives be available. However, Malawi is currently experiencing a great shortage of nurse-midwives. The exodus of nurse-midwives has contributed to this shortage. As of 29th March 2005, the Malawi Nurses and Midwives Council Validation Board indicates that 541 registered nurses have left the country due to poor working conditions. Most of these nurses are experienced and have worked more than 5 years (Nurse and Midwives Council of Malawi, 2005). In hospitals, there is high client to nurse-midwife ratio. This contributes to poor quality of care. According to the Malawi Demographic and Health Survey (2000), only 56% of women have a skilled attendant at the time of delivery. However, the survey does not indicate the availability of quality care. Currently, this figure is likely to be even lower than 56%. The departure of nurses from public hospitals has created a big gap in the clinical area for modelling of young nurses. This has a long-term negative impact on the nursing and midwifery profession in Malawi.

The British nursing register also shows that the number of nurses being certified from Botswana, Ghana, Malawi, Nigeria, Kenya, South Africa, Zambia and Zimbabwe has increased. Dr. William Aldis, a World Health representative to Malawi, describes the situation as catastrophic because nurses are the ones who hold the situation together in hospitals. This exodus of nurses to the West has created more than 60% unfilled nursing positions in Malawi and Ghana (Volqvartz, 2004). Such a situation creates a vicious cycle because as more nurses leave the hospitals, the working conditions worsen for the remaining nurses and as a result they are also tempted to leave as well. According to Dugger (2004), the sheer lack of skilled personnel is the major contributing factor to the poor health indicators in Malawi. It is not unusual to find one nurse-midwife caring for more than 50 patients during a shift. This leads to burnout syndrome and poor quality of care.

Besides nurse-midwives leaving the country, death predominantly due to HIV/AIDS has also contributed to the attrition of nurse-midwives. According to Muula et al (2003), the wastage of nurses in Malawi public hospitals due to death is at 2.3% per year. Malawi also loses nurse-midwives to research institu-

tions/projects, NGOs (both national and international) and to private practice. Some midwives are leaving the health sector altogether.

Inadequate Resources in the Health Facilities

Public hospitals in Malawi (serving a population of 11 million) are running with critical shortage of medical supplies and equipment. This makes provision of patient care, especially to the vulnerable groups, such as the pregnant women, very difficult. This can result in considerable delays in provision of care and poor quality care. In the hospitals where our students go for their clinical experience, it has become part of the norm to nurse a labouring woman on a bed without any linen and the woman completely uncovered. This is true especially if the woman does not bring enough of her own 'zitenje.' Sometimes, a midwife has to leave to go to another ward in search of supplies. This can lead to unnecessary deaths from emergency illnesses and frustration of nurse-midwives. From the authors' observations, this problem is worse now in the southern region of Malawi since the completion of the Malawi Safe Motherhood Project of the Southern Region of Malawi that used to supply essential obstetric drugs, and other medical resources. Currently, some second level hospitals' maternity departments are operating without vacuum extraction machines, surgical scissors and modern sterilisation equipment. Essential drugs such as oxytocin have been out of stock even in tertiary hospitals. The implications of shortage of oxytocin are enormous. Women who could have delivered normally have ended up being delivered by caesarean section that puts them even at a higher risk of delivery complications such as infection. This can further stretch the limited available resources because women who deliver by caesarean section have a long hospital stay compared to those who deliver vaginally.

Gender Inequality and Traditional Practices/Beliefs

Decreasing social and economic inequalities against women is key to safe motherhood (NGO Networks for Health, 2000).

Malawi is rich in traditional practices. Some of these cultural practices and beliefs strengthen the gender inequality that is already there. Some delays in seeking maternity care in pregnant women are due to the fact that women cannot make independent decisions to seek care when sick. They have to wait for male family members to decide when and where to seek health cares. Delay in seeking maternity services makes it difficult for midwives to provide optimal care to these women.

The majority of women in Malawi are not economically empowered. 75% of women have income that covers only half of their household's expenditure. Furthermore, only 51% of women who earn cash decide alone how their earnings are used (National Statistical Office Malawi, 2001). Women with no income of their own have even greater dependency on their male partner. This low socio-economic empowerment puts women in a situation whereby they cannot do much to improve their well being, without their male partner's support and/or approval. Therefore, as a midwife, one cannot be assured as to whether the health education given to such women will be utilised fully in promoting their health because of this lack of economic empowerment.

Some traditional practices put women at risk of contracting HIV infection. Such practices include the 'Fisi' and 'Shanzi' that are still being practiced by some tribes in Malawi. The Shanzi is a tradition that compels traditional leaders to identify a beautiful girl or woman to entertain a visiting chief in bed (Ntonya, 2004)

while the Fisi is a man who is used to sleep with a woman who has lost a husband as part of cleansing process or whose husband is infertile. Such practices can contribute to poor reproductive health and unsafe motherhood even before pregnancy occurs. According to the NGO Networks for Health (2000), high levels of maternal mortality are a symptom of a neglect of women's fundamental human rights. Practices like Shanzi and Fisi violate women's rights.

Recommendations

HIV/AIDS Pandemic

- Advocate for routine HIV testing for all childbearing and antenatal women to facilitate access to PMTCT services.
- Increase public awareness on significance of early antenatal booking. This helps in early identification and management of problems such as respiratory infections (Tuberculosis, pneumonia) which are common causes of maternal deaths with HIV/AIDS.
- Improve food security for all people. A starving pregnant woman who is also HIV positive is more likely to have poor pregnancy outcomes.

Shortage of Nurse-midwives

- Improve the working environment, salary structure and career progression ladder for nurse-midwives.
- Train more midwives. This can be done through improvement of the existing training institutions so that intake can be increased, and opening of new schools of midwifery.
- Bond students for a certain period for example, 2-3 years so that after graduation, they can work within public sector before they can decide to go anywhere. This can be done through the Nurses and Midwives Council of Malawi and through the scholarship system that is available in nursing schools. Such a strategy is operational for new nursing graduates in Zimbabwe and new medical graduates in South Africa.

Inadequate resources in Health Facilities

- Lobby Members of Parliament (such as women caucus group) to advocate maternal and child health as a national priority so that it gets the attention it deserves for resource and financial allocation.
- Commercialise some sections of public hospitals in order to generate funds to break even on expenditure so that the working condition is conducive.
- Mobilise non-governmental organisations/institutions in supporting public health facilities. This has recently worked as a short-term measure for Queen Elizabeth Central Hospital maternity unit.
- Institute/reinforce a monitoring and supervisory mechanism in all facilities for the management of resources.
- Introduce cost sharing. Expectant families should contribute a basic fee towards the purchase of basic resources necessary for the delivery of their baby. Delivery is usually not an emergency. Couples can save some money over the nine months period they are expecting their baby.

Gender inequality and traditional practices/beliefs

- Promote girl and women education. Education is key to improving women economic empowerment. This will in turn, help them in making decisions affecting their health.
- Involve male partners in maternal and child health services.

Traditional leaders can be enlightened to persuade men to get involved in the care of their wives and children. Therefore, maternal and child health services in Malawi need to be male friendly to ensure male partner involvement.

Conclusion

The maternal mortality ratio of 1120 per 100 000 live births is alarmingly high. Sustainable solutions are urgently needed. However, looking at the challenges addressed in this paper, no individual recommendation suggested above is likely to work. There is need for a multi-sectoral approach to solving the current problem of high maternal mortality ratio. As the White Ribbon Alliance for Safe Motherhood puts it 'safe motherhood is a matter of social justice and women's human rights' (NGO Networks for Health, 2000). Let us all join hands in helping our mothers enjoy their Rights to safe motherhood. A nurse-midwife is key to achieving this goal.

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