Original article:

Please, understand why village midwife performance is not optimum!

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Abstruct:

Background: Mother and baby's death is still a global isue. The presence of village midwife has been proved effective in decreasing pains and deaths. However, in the past few years, the contribution of village midwife in preventing deaths is questioned. The low performance of village midwife is regarded as the reason why the isue exists. ***Objective****:* To find out the reasons why village midwife performance is not optimum. ***Design***. The study used mixed methods with sequencial exploratory strategy. The study was started by collecting qualitative data, which was then followed by collecting quantitative data. The collecting of qualitative data was done by having focus group discussion (FGD) and thorough interviews, while the collecting of quantitative data was conducted by fulfilling questionaires. ***Setting****:* These activities had been carried out from August to November 2016 in 27 subdistricts in Indragiri Hilir Regency. ***Participants***: The data collecting was done by involving 5 facilitators, 2 interviewers, and 27 data collecting officers. There were 77 midwives who had been involved in FGDs, meanwhile 31 midwives were involved in thorough interviews and 439 midwives took part in fulfilling questionaires. ***Results****:* The obstacles which make the village midwife performance not optimum include health policies and regulations, competency, tools and infrastructure, demography, geography, security and safety, midwife intrinsic and family. ***Conclusions:*** Problems faced by village midwives are too complicated to overcome by midwives alone. The government should re-examine the policies and the regulations of village midwife, the standard of tools and infrastructure, incentives, sanctions and rewards.

Keywords: Midwife; village; performance; obstacle; mortality

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Introduction

The problem regarding mother, baby and infant's pain and death is still a global issue. The focus on decreasing mother's pain and death is a global health agenda.[1] Indonesia is an archipelago. Most Indonesians live in villages. The tough geographical condition makes the health service difficult to be given to all people, especially those who live in rural areas. To solve the problem, the government has posted midwives in these rural areas so that the people in the rural areas can have health service provided by the government. The placement of midwives in rural areas is expected to improve community health and decrease mother, baby and infant's death. The result of the analysis proves that the placement of midwives in rural areas can effectively decrease pain and deaths.[2-5] Darmstadt reveals that mother and baby's death can be decreased around 20-30% by applying childbirth service from skilled midwives.[6] Therefore, the government has focused on giving

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childbirth service by skilled midwives. However, in some villages, people still choose shamans (it is called "*dukun*") to help the childbirth. Shamans have been present in many villages. This also happens in many countries with low income per capita where childbirth is done in houses and without the help of skilled midwives.[7-10]

In the past few years, there is a phenomena showing a quite significant increase of mother's death when giving birth. This is why the presence of village midwives is questioned. The cases on mother's death when giving birth in villages make many parties focus their attention on the village midwife performance. The study conducted by WHO shows the low quality service given to the community so that the effort to decrease mother's death is not effective.[11] Some studies show low quality of health service and the improper childbirth service can be seen from the negotiation of access of service, obedience and effectivity of service.[12-14] Many parties accuse that the village midwives are the ones who should be responsible for this condition. To comprehend the roots of the problems, we have conducted investigations in order to find out the reasons why midwife performance are not optimum. This will help the government comprehend the roots of the problems so that they can establish the alternative problem solving for high mortality of mother, baby and infant.

Methods

The study used mixed methods with sequencial exploratory strategy, which was a research method started by data collecting and qualitative data analysis, then followed by data collecting and quantitative data analysis.[15] The qualitative design used phenomenologic approach, which stated that truth could be gained by understanding the phenomenon or sign that reflected from the objects which were studied. All aspects which became the obstacles of the village midwives were tracked by focus group discussion and thorough interviews. The technique for taking samples was purposive sampling. After getting the unsupporting factors, the results were confirmed by doing the quantitative study. Quantitative design used cross-sectional approach. The study was used for generalizing the obstacles faced by village midwives in giving childbirth service. The data collecting was done from August to October 2016 in 27 subdistricts of Indragiri Hilir Regency, Riau Province, Indonesia. The number of participants involved in focus group disscussion (FGD) were 77 midwives and 39 in thorough interviews, while the number of respondents involved in fulfilling questionaires were 439 midwives.

The qualitative data collecting used two methods. They were FGD and thorough interviews. FGD was done to find out aspects which were related to problems generally faced by village midwives in giving childbirth service. The outcomes of FGD were then explored by conducting thorough interviews.[16] Five facilitators and five notulents were recruited and trained to gather information from village midwives. Out of 87 midwives who were invited to do FGD, 77 midwives from 27 subdistricts attended the program which was held in a hall. All FGD participants were divided into five groups. Each group had 15-16 village midwives who were guided by a facilitator and a notulent. The outcomes of FGD were used as basic guidances of the interviews.

Thorough interviews were done to find out individual obstacles faced by village midwives in giving childbirth service. There were 31 thorough interviews which had already been conducted in Indonesian language using interview guidances. Thorough interviews were conducted by two skilled and experienced personels in qualitative study. Most thorough interviews were conducted face to face in the participants' houses, interviewers' houses, interviewers' work places, and restaurants recommended by the participants. But, some participants were interviewed by phone because the midwives houses were so difficult to access. Thorough interviews were focused on individual experience of the village midwives. The results of the interviews were then processed and verified. Data verification was done by using data triangulation. There were 8 additional thorough interviews for 5 village chiefs and 3 heads of community health centre which had been done to help verify the data.

To generalize the obstacles, the results of FGD data analysis and thorough interviews were made in the form of questionaires which were then distributed to all village midwives in Community Health Centres and Supporting Community Health Centres in Indragiri Hilir Regency. There were 27 representative midwives from 27 subdistricts who had been recruited and trained to give explanation on the study and how to fulfill the questionaires. Each subdistrict representative distributed the questionaires to all midwives in her region. Out of 653 questionaires which were distributed to all midwives in Community Health Centres and Supporting Community Health Centres, 439 questionaires were returned and processed and analized. Ethical approval was taken before study. The data was then processed unvariably and presented in the form of frequency distribution table as shown in table 1.

Table 1 Midwife's obstacles in villages (n=439)

No	Obstacles	The number who experienced	%
1	Policies and regulations 1. Policies on regulating the health personels		
	1) Uneven placement of health personels	132	30.1
	2) There was no on duty schedule among village midwives	290	66.1
	3) Specialist doctor on midwife was not always available	46	10.5
	4) Regulations which compelled health personels to help childbirth in health facility	110	25.1
	5) Difficult process of getting practice permit	28	6.38
	2. Work load		
	1) There were too many reports which should be done by village midwives so that they could not focus on their main task as midwives	161	36.7
	2) There were too many programs which should be managed by village midwives	126	28.7
	3) There was no clear job description	296	67.4
	3. Transit house		
	Transit house was not prioritized for those who suffer from complication	44	10
	4. Health cost		
	1) Monthly incentive could not cover transport and accomodation cost, especially for those who were hired as contractors and volunteers	342	77.9
	2) Cadres were not active because their incentives were so small	65	14.8
	3) There were rich people who misused the health insurance which was specially given for poor people	94	21.4
	4) There was no fund for village midwife's activities	3	0.68
	5) The community found it difficult to get national health insurance	287	65.4
	5. Partnership of midwife and shaman		
	1) There was no partnership of midwife and shaman	293	66.7
	2) There were still many active shamans	293	66.7
	3) There was no clear sanction and regulation for shamans who gave childbirth service	293	66.7
	4) Partnership of midwife and shaman had never been evaluated	11	2.51
	6. Rewards		
	1) There was no compensation or reward for midwives who had given their best service	158	36
	2) The chosen model midwife was usually the midwife in cities, not in villages	8	1.82
	7. Sanctions		
	There was no sanction for midwives who were not available in their work places or who did not come to the villages	121	27.6
	8. Audit maternal perinatal		
	Audit maternal perinatal did not work well	21	4.78
2	Competency		
	1. Minimum training for village midwives	205	46.7

No	Obstacles	The number who experienced	%
	2. Low skill of midwife in diagnosing childbirth cases	93	21.2
	3. Low skill of midwife to communicate in local language	56	12.8
	4. Low skill of midwife in negotiating with community figures	93	21.2
	5. Some midwives could not swim	136	31
	6. Many skills which should be applied on site, but they were not taught in universities	114	26
	7. Village midwives did not have work experiences	291	66.3
	8. Midwives did not understand how to make reports on local area monitoring for mother and children's health	223	50.8
3	Tools and infrastructure		
	1. Village midwives' houses were improper	90	20.5
	2. The condition of health facilities were improper	48	10.9
	3. Improper infrastructure for giving childbirth service	128	29.2
	4. Facilities for laboratory medical check up were incomplete	11	2.51
	5. Electricity was not provided for 1x24 hour so that the cool temperature needed for medicine (oxytosin, vaccin) storage was not guaranteed	143	32.6
	6. There was no waiting room for childbirth service	3	0.68
	7. Some medicines received by the medical personels were almost expired	13	2.96
	8. Fe Tablet, vitamine A, aboket, oxitosin were not available in Community Health Centres	13	2.96
	9. There was no water ambulance like *pompong* (skiff)	247	56.3
	10. Lack of clean water	7	1.59
4	Demography		
	1. Economic status of middle down community	245	55.8
	2. Education		
	1) Low education of community	278	63.3
	2) There were still some illiterate people	97	22.1
	3. Life pattern of community		
	1) Lack of community awareness on the importance of health	287	65.4
	2) Community used dirty river water, while river toilets were only few metres from places where the people did their activities (like bathing and washing)	287	65.4
	3) Many people still defecated in any places they wanted	15	3.42
	4. Culture		
	1) The community chose shamans to help childbirth	293	66.7
	2) The community chose to give birth at home	351	80
	3) Too late for handling because of the family incapability to get referral for decision making	46	10.5
	4) Culture of seniority and juniority among medical personels	6	1.37
	5) Ratio of village midwives and number of villagers was not appropriate	93	21.2
5	Geography		
	1. Most of the area are territorial waters so that it was difficult for midwives to get referral	189	43.1

No	Obstacles	The number who experienced	%
	2. Number of midwives was not sufficient for some specific areas and some areas were not reachable	149	33.9
	3. Bad signal in villages so that it was difficult to consult with competent doctors	17	3.87
	4. High-low tide cycles		
	1) Difficulty to get referral when low tide because *pompon* could not enter the village ditch/trench, so the patient was transported by cart or carried using a chair	224	51
	2) When raining and low tide, there was no alternative transport to get referral	47	10.7
	5. The distance among villagers' houses is far, so it was difficult to visit every house	18	4.1
6	Security and safety		
	1. Midwives felt unsecured living in villages because security officers in charge were often unavailable in the villages	121	27.6
	2. There were shamans who suffered from HIV-AIDS	1	0.23
	3. Fear the danger of territorial waters (the danger of crossing the rivers)	164	37.4
7	Interpersonal midwives		
	1. Midwives were still young, so there was lack of trust among the villagers	163	37.1
	2. Midwives' appearances and characters showed immaturity	55	12.5
	3. Midwives were not married, so there was lack of trust	55	12.5
	4. Midwives were not confident	60	13.7
8	Family		
	1. Midwives' families lived in cities, so they did not want to live in villages	43	9.79
	2. Midwives were not in place because they took care of their families who were sick	5	1.14

Results

Policies and regulations

Recruitment and distribution of midwives are based on health policies and regulations.[17-18] Health policies and regulations can facilitate or obstruct village midwives' performance. Obstacles faced by village midwives related to government policies and regulations are bad management of health personels, high work load, selection of the use of transit houses, insufficiency of health cost, midwife-shaman partnership which was only an agreement, no reward for midwives with high performance and no sanction for midwives with dereliction of duty, audit maternal perinatal did not work well.

"*I can not do all given tasks. I feel envied because there are only few midwives in my village, but there are more in other villages*" (thorough interview, village midwife).[19-20]

Competency

The incompetency of midwives in giving childbirth service was caused by the lack of education for preparing midwives, lack of training for midwives, and midwives did not have work experiences before they were placed in villages.

"*We feel that we do not get sufficient knowledge, skills and experiences during our training in order to be able to work well onsite"* (FGD, village midwife).[21]

Tools and infrastructure

Even good competency will not be useful if it is not accompanied by sufficient tools and infrastructure. Midwives complained about improper condition of village midwives' houses, improper condition of health facilities, insufficient infrastructure for giving childbirth service, incomplete facility of laboratory medical check up, electricity which was not provided for 1x24 hour so that the cool temperature needed for medicine storage was not guaranteed, no waiting room for childbirth service, some medicines received by the medical personels were almost expired, some essential medicines for women who were pregnant

and giving birth were not available in Community Health Centres, no water ambulance like *pompon*.

"*How can I work well when the condition of many childbirth posts in the village is not good, the tools/ equipments are broken or improper, and the electricity is not 1x24 hour. I also find it difficult to get clean water*" (thorough interview, village midwife).[22]

Demography

Midwife obstacles also came from demography factors including economic status, education and knowledge, culture and the ratio between midwives and number of villagers. Demography factors influenced the community decision towards health service given, and they preferred to get informal health service from shamans.

"it is very hard to work alone, with community's lack of understanding on health. I must give childbirth service and at the same time I have to change their mindset. It is not an easy work."(thorough interview, village midwife)

Geography

Geographical problems were often the classical reasons for avoiding responsibility. Many village midwives' complains were neglected for the reason that geographical condition could not be changed. So, midwives had to make efforts to find the solution of their own problems. Many midwives felt frustrated and finally quit. This study revealed that geographical problems were very disturbing for midwives. Some of the geographical problems were as follows: most areas are territorial waters so that midwives found it difficult to visit the community, number of midwives was not sufficient for specific areas and some areas were not reachable, bad signal in villages so that it was difficult to consult with competent doctors, obstacles to get referral were related to high-low tide of river water and the distance among villagers' houses was too far away which made it impossible to visit every house. When low tide, *pompong* (small boat) could not go through the village ditches or trenches so the midwife and villagers had to reach the bank of the river on foot (patient was carried in a litter) or by motorcycle.[23] After reaching the bank of the river, they still had to pass the river mud to get onto the boat. The condition was quite different when it was raining and the river water was low. Referral could not be done because the patient would get wet, and travelling on a skiff (it is called *pompong*) when raining was very dangerous because the big waves of the river water might make the *pompong* unstable which meant there was a high risk of getting sunk.

"We have already complained about this, but we do not get any response or solution of the problem. So, we choose to keep silent and do the job the best we can" (FGD, village midwife)

Security and safety

To getthe optimum result, one needs to work in a secured condition. Unsecure feeling will put someone in fear so that he/she will not be able to focus on the job. Midwives admitted that they did not want to live in the village because village security officers who were in charge of the areas were often unavailable. They were also in fear of the danger of territorial waters because some villagers had been the victims of the wild animals which lived in the water. The more surprising thing was that the midwives felt worried when giving childbirth service because there were active shamans who were already infected by HIV-AIDS. The ignorance of shamans on preventing infection would increase the risk of patient to get infected by HIV-AIDS.

"I feel afraid to help childbirth since there is a shaman in my village who has been infected by HIV-AIDS. Shamans do not understand the act of preventing infection and I do not know the patients who have been given childbirth service by the shaman and got infected. Up to present, there is no interference from the Health Agency, so I really feel worried about it" (thorough interview, village midwife).

Interpersonal midwife

Interpersonal obstacles faced by midwives were related to the young age of midwives, midwives' appearances and characters which showed immaturity, midwives were not married, and lack of confidence.

"What shall I do? I do not feel confident when working alone. It is different from when I was still studying in university. Now, I have to work alone and be responsible for my work." (thorough interview, village midwife).

Family

Midwives had not only to be responsible for their work, but also for their family. The responsibility for taking care of the family was the crucial factor which should be fulfilled by midwife as member of the family. Some midwives refused to live in the village because their husbands worked in cities and their children also studied in cities too, so these midwives had to go to the cities frequently in order to be able to stay together with their family. Besides, there were midwives who could not live in the village because they had to take care of their family who were sick and treated in city hospital.

"*Now I am pregnant, but I still have to come and go*

from village to city because my husband work in the city and my children study in the city too. If we have to move to the village, what about my husband's work and my children's education? Meanwhile, there is no proper job and good school for them in the village." (thorough interview, village midwife)

Discussion

From all roots of problems seen as the causes which made village midwife performance not optimum, only few (10.5%) which were caused by village midwives. Unclear job description made them work much harder. Too many tasks and high work load which should be accomplished by village midwives made them unable to focus on their work, and this resulted in bad work performance. Many midwives had to handle more than one village.[24] They worked alone, like a super hero. They worked in a large area without work safety guarantee, without any facility to reach the area, and with difficult and expensive access. Meanwhile, the incentive given to the midwives was not appropriate for the work load and high risk of safety they had to face.

The public pointed out the low performance of midwives and demanded that the midwives had to work harder, but they forgot the obstacles faced by the midwives and the sacrifice that they had made in the village. There was no reward for the sacrifice they had made. The demand to improve the performance was not accompanied by increase of wealth, and high risk of safety was not in line with the incentive they received. Village midwives bore all these burdens on their own. When they were blamed and cornered, they chose to keep silent because no one would hear them and no one cared about their fates. Do we realize that midwives are bio-psycho-socio-cultural-spiritual creatures who also have needs which should be fulfilled? A midwife is not a robot which can work for 24 hours per day. A midwive is a human, a woman, a mother and someone who has to play the role as human, member of family, wife and child. Even a robot can be broken if it is operated over its capacity.

The problems faced by midwives in the village are not simple. There should be a commitment to help solve the midwives' problems. The central government should re-examine the work load of village midwives so that midwives can work well, formulate the job description for village midwives, determine the requirements to become village midwives, set kinds of selection and training which are necessary for the village midwives candidates, give good incentive for village midwives, set the standard of tools and infrastructure, and set the standard of security and work experience. Work experience as a midwife and years of experience will influence the effectivity and efficiency of service given by midwives.[25]

Meanwhile, the local government needs to improve competency, tools and infrastructure for village midwives. Medical personel's competency is an absolut factor which should be fulfilled in decreasing mother's death, therefore training for medical personels is of vital importance to prevent complication.[11, 26] However, the benefit of having competency can only be felt when it is supported by proper tools and infrastructure, and decision made by the community to choose skilled health personels in helping childbirth. Next, access to get to the health centre is one of the determinants for the community to have health service. Thaddeus states that mother's death can be avoided if women can access the health service and take a better benefit of it, especially when there is a complication.[27] The question is, what was the barrier that made them unable to access health service? The facts showed that many women had serious problems to access health service.[11] Geographical condition and difficulty in having the access made the community unable to reach basic health facility.[28] Though the barrier is caused by nature, there should be a solution to the problem. The management of land and water transportation for health service activities should be considered wisely. Supporting environment is needed as a bridge for health service and community.[26, 29-30]

This access is not only for midwives and community who want to reach the health facility, but also for midwives who want to visit the community. There were arguments saying that midwives had to do home visit to the community who did not want to go to the health facility. However, findings in this study showed that water transport was not always available. Midwives needed at least 2 days to get to a sub village and got back to the Supporting Community Health Centre, which would cost them 100,000 rupiahs per sub village (not including meals and other costs). A village consists of around 13 sub villages. If there were many villagers who were not aware of the importance of health service, particularly childbirth service by health personels, midwives needed to do home visits. The questions are; how long did it take for a midwife to do home visit in all sub villages? How many time did a midwife have to do home visit in order to change the villagers' mindset? How about the service which should be given in Supporting Community Health Centre if the midwife was not

available? How much money did the midwife have to spend for all home visits? How much was the monthly incentive for a village midwife? Based on the facts, land and water transport related to the health activities should be considered crucial.

Besides, educational sector needs to be involved in supporting the village midwives. Mrisho and Caldwell reveals that level of education in villages affects the choice of finding health service.[7, 31] Local government needs to consider the availability of educational facility and placement of teachers to ensure that all villagers are not illiterate. This way can help midwives to change the villagers' point of view on the importance of health. Educational sector can also help midwives to eliminate improper culture which endangers the villagers' health. Economic sector needs to hold trainings to motivate the villagers to gain business ideas by optimizing local potential. Improvement on education and economy is expected to give the villagers new insights and eliminate the culture which inflicts a health loss upon the community.

A study by Chiarella found out that challenges faced by village midwives are related to the low sensitivity of culture and the inability of midwives to reflect the complexity of service given.[32] The role of midwives and shamans is very important, especially for villages which have not got optimum health service. Since 2007, the government has anticipated it by initiating a partnership program between midwives and shamans through health program development for mother and children. The partnership is expected to help a good cooperation between midwives and shamans where midwives give birthchild service and all medical treatment, and at the same time the shamans give nonmedical treatment such as massaging the mother's back, encouraging the mother, helping the mother wash the blood, and helping the family take care of the placenta.[23, 33] This study found out that partnership between midwives and shamans worked only based on agreement. In reality, many shamans worked on their own and they were not interfered. This was in accordance with a study by Titaley which revealed that such a partnership did not work well in many villages. It was also related to the small remuneration given to them. It was very difficult to give sanction to them because the shamans and the villagers already had a close and mutual cooperation. They claimed that the mother had already given birth, so they did not need a midwife anymore.[23]

According to researchers, partnership program between midwives and shamans was one of inexplicitness and commitment of the government to stop shaman practice. The fact was that the partnership program did not work well since there were many rule breakings in it. So far, the government still tolerated the existence of shamans and this was the reason why the community came to the shamans. Midwives were blamed for the community decision to choose a shaman as the childbirth helper, meanwhile nobody blamed the community and shamans. The policy on partnership between midwives and shamans needed to be evaluated. Considering that there is a negative impact and danger on shaman practice, it is wiser that the government takes a resolute step over shaman practice. The ilustrative description for this issue was that most villagers chose shamans because of financial problems and they wanted to have their childbirth service at home. Therefore, partnership between midwives and shamans was not an appropriate solution to the problem. Childbirth service by a midwife and shaman would cost more for the community because they had to pay the midwife and the shaman. When there was an argument that the community would pay the same cost because the payment for the shaman would be taken from the midwife's payment, then how much money did the midwife get as a professional medic? Was this fair enough for the midwife? This meant that the low monthly income for the midwife had to be reduced for the shaman's payment.

The government needs to make a regulation which applies an explicit sanction for shamans who still give childbirth service to the community. The explicit sanction is meant to make the shamans obey the regulation. Of course, the implementation of the regulation is more important than just a formal writing. The consequence is that the midwife must be available at all times. To overcome unavailability of midwife when needed, there must be at least two midwives in a village so that if one of them is absent because she has to visit her family or she has to attend training programs, the other midwife can take it over. Besides, to prevent the domination of a midwife, the Community Health Centre must have on duty schedule for the village midwives. Sanction will be given to the midwife who does not comply with the schedule. To enhance this, it is necessary to make a working contract agreement that midwifes will live in the village. To motivate the midwives to perform well, and to avoid the asumption that midwife is just a jumping stone to get a better job, civil servant status should be given as a reward to a village midwife who performs well for three substitute work periods.

Assesment of midwife performance should be done periodically to evaluate whether a midwife can be considered a model midwife. The selection of a model midwife and the submission of compensation on performance must be based on clear assesment indicators so that it will prevent social envy among midwives.

Research Significancy

Findings of the study showed the unsupporting aspects of village midwife tasks. The findings would be considered positive feedbacks for the government, particularly the local government so that they could improve and optimize the role of village midwives in decreasing mother, baby and infant's deathby facilitating alternative problem solution to minimize the obstacles faced by village midwives. These findings would also be used as basic knowledge to formulate local policies.

Conclusion

Problems faced by village midwives are complicated and can not be solved by midwives themselves. They need involvement from the government, professional organizations, educational institutions, community figures and other related sectors in order to facilitate the solution of the problems faced by village midwives. The government needs to re-examine the policies and regulations of village midwives, the standard of tools and infrastructure, incentives, sanctions and rewards. The policy of one midwife for one village should also be evaluated.

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Author Contributions

II have made the study concept. All authors have been involved in collecting the data of FGD. II dan SH have conducted thorough interviews. HA, and ND monitored the return of questionaires. II, ND, and HS have done the data analysis. II made the draft of the journal. All authors have given feedbacks and revision to the final journal. All authors have read, commented and approved the final journal.

Competition Interests

All authors declare that they have no competing interests within this study.

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