Working lives of maternity healthcare workers in Malawi: an ethnography to identify ways to improve care

Abi Merriel, PhD; Michael Larkin, PhD; Julia Hussein, MRCOG; Charles Makwenda, MSc; Address Malata, PhD; Arri Coomarasamy, MD

BACKGROUND: Maternal mortality in East Africa is high with a maternal mortality rate of 428 per 100,000 live births. Malawi, whilst comparing favourably to East Africa as a whole, continues to have a high maternal mortality rate (349 per 100,000 live births) despite it being reduced by 53% since 2000. To make further improvements in maternal healthcare, initiatives must be carefully targeted and evaluated to achieve maximum influence. The Malawian Government is committed to improving maternal health; however, to achieve this goal, the quality of care must be high. Furthermore, such a goal requires enough staff with appropriate training. There are not enough midwives in Malawi; therefore, focusing on staff working lives has the potential to improve care and retain staff within the system.

OBJECTIVE: This study aimed to identify ways in which working lives of maternity healthcare workers could be enhanced to improve clinical care.

STUDY DESIGN: We conducted a 1-year ethnographic study of 3 district-level hospitals in Malawi. Data were collected through observations and discussions with staff and analyzed iteratively. The ethnography focused on the interrelationships among staff as these relationships seemed most important to working lives. The field jottings were transcribed into electronic documents and analyzed using NVivo. The findings were discussed and developed with the research team, participants, and other researchers and healthcare workers in Malawi. To understand the data, we developed a conceptual model, "the social order of the hospital," using Bourdieu's work on political sociology. The social order was composed of the social structure of the hospital (hierarchy), rules of the hospital (how staff in different staff groups behaved), and precedent (following the example of those before them).

RESULTS: We used the social order to consider the different core areas that emerged from the data: processes, clinical care, relationships, and context. The Malawian system is underresourced with staff unable to provide high-quality care because of the lack of infrastructure and equipment. However, some processes hinder them on national and local level, for example staff rotations and poorly managed processes for labeling drugs. The staff are aware of the clinical care they should provide; however, they sometimes do not provide such care because they are working with the predefined system and they do not want to disrupt it. Within all of this, there are hierarchical relationships and a desire to move to the next level of the system to ensure a better life with more benefits and less direct clinical work. These elements interact to keep care at its most basic as disruption to the "usual" way of doing things is challenging and creates more work.

CONCLUSION: To improve the working lives of the Malawian maternity staff, it is necessary to focus on improving the working culture, relationships, and environment. This may help the next generation of Malawian maternity staff to be happier at work and to better provide respectful, comprehensive, high-quality care to women.

Key words: healthcare workers, low- and middle-income countries, Malawi, maternal health, quality improvement, working life

Introduction

Malawi is a low-income country, with a high maternal mortality rate of approximately 349 deaths per 100,000 live births.[1] This figure reflects a significant government commitment to improving maternal health, which reduced maternal mortality by 53% between 2000 and 2017.[1] However, subsequent political events have resulted in poorer health system financing and less investment in improving maternal health outcomes.[2]

From the Institute of Metabolism and Systems Research, College of Medical and Dental Sciences, University of Birmingham, Edgbaston, Birmingham, United Kingdom (Dr Merriel); Department of Psychology, School of Life and Health Sciences, Aston University, Birmingham, United Kingdom (Dr Larkin); Maternal Health, Aberdeen, United Kingdom (Dr Hussein); Fintray Gardens, Hatton of Fintray, Aberdeen, Scotland (Dr Hussein); Parent and Child Health Initiative, Lilongwe, Malawi (Mr Makwenda); Malawi University of Science and Technology, Limbe, Malawi (Dr Malata); Institute of Metabolism and Systems Research, College of Medical and Dental Sciences, University of Birmingham, Edgbaston, Birmingham, United Kingdom (Dr Coomarasamy); Population Health Sciences, Bristol Medical School, University of Bristol, Bristol, United Kingdom (Dr Merriel).

The authors report no conflict of interest.

This study was funded by Ammalife, a registered charity in the United Kingdom. The funding source had no role in the design or interpretation of the study.

Cite this article as: Merriel A, Larkin M, Hussein J, et al. Working lives of maternity healthcare workers in Malawi: an ethnography to identify ways to improve care. Am J Obstet Gynecol Glob Rep 2022;2:100032.

Corresponding author: Abi Merriel, PhD. abi.merriel@bristol.ac.uk

2666-5778/$36.00

© 2021 The Authors. Published by Elsevier Inc. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/)

http://dx.doi.org/10.1016/j.xagr.2021.100032

AJOG Global Reports at a Glance

Why was this study conducted?

This study aimed to identify target areas for interventions to improve Malawian maternity care with a focus on maternity healthcare workers and improving their working lives.

Key findings

There seemed to be elements within the healthcare context that are dictated by an ingrained "social order," which sets out processes, clinical care, and relationships. Collectively, these elements may affect the working lives and quality of care.

What does this add to what is known?

To make vital changes, the social order needs to be disrupted. Change is challenging to the staff. Here, we identified 2 low-cost solutions by encouraging leadership behaviors in senior clinical staff and working with managers to better understand the staffing needs within the maternity service.

Many initiatives, such as community interventions, are important and have been used to improve maternal health in Malawi[3,4]; however, the health system must provide high-quality maternity care. One important facet of this is having competent and motivated staff.[5] The key to this is recruiting, retaining, and appropriately training maternity teams. Some interventions targeted at staff have been tested in Malawi, such as improved support for staff[6] and interventions to improve clinical care.[7,8] However, in addition to improving clinical skills, improving working lives for staff can affect the care they provide and their willingness to remain in the system.[8] To achieve this goal, the most important "targets" for change must be identified, and appropriate interventions must be developed, tested, and critically appraised. For example, it has been shown that supportive supervision is important in retaining staff, as the approach facilitates supervision of staff, especially midlevel health providers who are often poorly overseen, and ensures that they feel supported[9]; however, its implementation can be unsupportive and demotivating.[6]

To try to identify possible approaches to improve maternity care in Malawi, we carried out an ethnography in district hospitals in Malawi, focusing on maternity healthcare workers (mHCWs) and how their working lives could be improved.

Materials and Methods

Setting

The study was conducted in community, district, and referral hospitals close to Lilongwe, the capital city of Malawi. The characteristics of the hospitals are described in the Table.

Data collection

Observational data were collected by the first author (A.M.) working 4 to 8 weeks

TABLE
Characteristics of Study Sites

Characteristic	District referral hospital	District hospital	Community hospital
Number of deliveries	15,000 deliveries per year	3700 deliveries per year	4500 deliveries a year
Location	Capital city	Main district town	Small town
Staffing	Obstetricians, general practitioners, trainee obstetricians, clinical officers, nurses, and auxiliary staff.	Two doctors who are responsible for district health services, with no specific time for obstetrics, clinical officers, nurses, and auxiliary staff.	Clinical officers, nurses, and auxiliary staff.
Other information	The inpatient business is maternity and women's healthcare. It acts as a referral unit but frequently refers more complex cases to the central hospital where specialist services are more available.	During the study period, a tarmac road was built all the way to the hospital. It is approximately 1 h from the capital city. It is a hospital that receives referrals from all health centers and community hospitals in the district. They refer to the central hospital as they are not in the same district as the referral hospital.	The hospital is accessed by a tarmac road and is 30 to 40 min from the capital city. The hospital receives referrals from the surrounding health centers and refers to the district referral hospital or central hospital.
Specific department	The observations took place on the high-risk postnatal ward, as the hospital was too large to observe practice in all areas. This ward had 10 rooms to receive women and had approximately 70 beds.	The observations took place on the labor and postnatal wards.	The observations took place on the maternity ward, which handled antenatal patients and outpatient assessments (not antenatal care), labor ward, and postnatal ward.

Merriel. Improving Malawian maternity care. Am J Obstet Gynecol Glob Rep 2022.

in the field at a time for 12 months (July 2015 to July 2016, a total of 7 months of observations). During field visits, jottings were made as aide-memoire, and these were used to produce more detailed, freehand, electronic notes (in Microsoft Word) immediately on leaving the field.[10,11]

The staff were observed in their daily tasks and their interactions with patients, colleagues, and managers on the wards. This was supplemented by discussions with the staff about their working lives. During the ethnography, the first author (A.M.) was increasingly struck by how the interactions of the staff seemed to underpin the functioning of the hospital and therefore focused on these more complex relationships, as they seemed to reveal and allow a deeper understanding of the working environment than the interactions of the staff with their physical surroundings.

Access

The district health officers assisted with obtaining local ethical approval by writing letters of support. Furthermore, their permission guaranteed access to the wards for observations. The first author (A.M.) was viewed by local staff as a foreigner, which initially affected their interactions. As time progressed, and familiarity developed, the staff became more open about themselves and their working lives.

Position of authors and reflexivity

Neither data gathering nor analysis is a neutral activity.[12] As a British obstetric trainee, the first author (A.M.) had up-to-date clinical knowledge and training in obstetrics in high-income settings. However, because delivering care would have been incongruous with the environment where there were no or few doctors, a conscious decision was taken not to practice clinically; to facilitate this, A.M. did not obtain a Malawian medical license. However, because of practicing in a high-income setting, the first author (A.M.) had prior beliefs about how maternity care should be practiced. Therefore, efforts were made to understand and attenuate this effect by developing diverse collaborations and discussing ideas with participants and other researchers and health workers in Malawi.

The project team consisted of M.L., a reader in psychology, who assisted with the data analysis. J.H., a maternal health specialist, who has worked in Malawi, guided the process and practicalities. C. M. runs a research nongovernmental organization in Malawi, and he provided practical support. A.Ma. is a professor of nursing and midwifery in Malawi. She provided access to the field and detailed discussions about the interpretation of working lives. A.C., a professor of gynecology, provided a clinical perspective.

Data analysis

This iterative process enabled the development of emergent themes and guided data collection.[10,13] NVivo (version 10 (2014); QSR International Pty Ltd, Australia.) supported this process.[14] We developed patterns, clustered concepts,[13] and compared cases within the themes and within and between sites and then related each theme to the others.[12] We discussed how they related to the conceptual basis for the analysis: the social order of the hospital.

The social order of the hospital

We developed a conceptual framework, based on Bourdieu's political sociology,[15–18] to underpin our analysis. Many of the concepts have been supported in previous ethnographies based in Malawi.[19–21] The social order was created by the "social structure of the hospital" and a "set of rules," which governed the workplace and meant that mHCWs followed the "precedent" of those that came before them. Box 1 explains this further.

Box 1 The social order of the hospital

The social structure of the hospital: Malawi's hospitals, like it's society, are hierarchical. This is defined by a person's social, cultural, and economic capital.[14] As has been observed in Malawi previously,[18-20] access to capital was associated with higher status and a sense of entitlement. The hospital had its own hierarchy, manifesting as deference to superiors who had more power to decide who got what and when, further bolstering their power.

Rules of the Hospital: There seemed to be a set of rules that governed the workplace. Bourdieu[17] argued that our social world is made up of "fields," where "agents" form identifiable groups. These different "fields" recognized each other and struggled for power. We saw staff groups as "fields" and individual staff as the "agents." Within these fields, there were rules that governed membership to the group.[15] These unwritten rules dictated the hierarchical situation in which staff interacted with each other and the patients.

Precedent: seemed to dictate how the staff worked. Bourdieu believed that a particular reaction cannot be predicted, but there is limited diversity of possible reactions. There was no conscious determination of these behaviors, but within groups, actions were relatively homogenous.[14] We saw members of different staff groups drawing on a distinctive repertoire of clinical and interpersonal behaviors. These likely resulted from observing those before them and cemented their membership to their "field."

The "social structure," "rules," and "precedent" interacted to form the "social order of the hospital." It was clear that these concepts were intimately linked and that they affected each other. Therefore, we drew on the social order of the hospital to illuminate how the staff interacted and behaved at work.

Ethics

Ethical approval was obtained from the University of Malawi College of Medicine Research Ethics Committee on February 27, 2015 (approval number P.09/14/1635-) and the University of Birmingham on October 30, 2014 (ERN_14-0878).

The clinical managers of each hospital provided consent for the inclusion of their maternity unit in the study. Individual staff members were provided with information and could opt not to be observed at work by individually informing the study team, individual consent was not obtained, and patients received information from the staff and posters.

Results

Each mHCW's experience at work was individual, but working life across the sites was remarkably similar. Therefore, we discussed the findings from all the sites as a whole.

We identified 4 important themes in the analysis: processes, clinical care, relationships, and the Malawian healthcare context. These areas are considered within the conceptual framework and illustrated in Loveness's story (Box 2). Loveness's story (names changed) is a powerful example illustrating the challenges faced by women and mHCWs in Malawi.

Context: the realities of working life

Working in a government hospital is challenging because of inadequate resources. For example, there are not enough beds, there are regular blackouts, often no piped water, or fuel for ambulances in emergencies, and there is a lack of basic clinical equipment (eg, sphygmomanometers).

A further challenge is that there are not enough staff to do the work. This is often exacerbated by the fact that the staff are often away at training courses, performing other administrative duties, or at funerals; this increases the pressure on the remaining staff. This often meant

Box 2 Loveness's story

Loveness's Story: Eclampsia

At 8 AM on a busy day on the maternity ward, Loveness was at the end of a queue of women waiting on the floor outside the labor ward. In the late morning, Loveness was last to be seen. She was lying down, eyes wide open, and no handheld notes. She could not communicate with Joshua, the nurse technician on the labor ward. Joshua requested for her relative to come (guardian). Moments later, Loveness started to have an eclamptic episode. Joshua observed, shouted "eclampsia" and approached Loveness hastily. Two auxiliaries, Kelly and Chimwemwe, arrived to help. The clinical officer, Giles, stepped out of the office. Joshua took Loveness's blood pressure and noticed it was high. He asked for the eclampsia tray, drew up the immediate treatment, and administered the medication. The guardian arrived and looked meek. Giles, who was observing, asked the guardian for Loveness's notes.

A non-maternity nurse, Destiny, arrived to help and decided that Loveness should be on a bed. The auxiliaries, nurses, and guardian worked together to lift Loveness onto a bed that was hastily found. This was more difficult because Loveness was in the corridor and there was a blackout. Destiny informed me that she was from the outpatient department, but when she heard that we were busy on the maternity ward, she came to help.

When Giles returned, he wanted to perform a caesarean section, but there was no sterile equipment. They could not send Loveness to the referral hospital because there was no fuel for the ambulance and the family could not afford to rent a car. Joshua was writing his notes and completing the medication and observation charts. He informed me that he would like to give another medication, but it was not available.

Joshua took Loveness's blood pressure, and it was almost normal. He smiled because she was stable. Furthermore, he stated, "I hate registering MD [maternal death]." I asked him what his plan was. He informed me that she needed hourly observations while waiting for delivery.

The following morning, Loveness was still in the corridor. She looked much more alert and was able to communicate; however, she was still pregnant. Joshua informed me that when the packs arrived, a blackout occurred. Therefore, they were unable to deliver the baby. However, at that moment, packs, power, and people were available.

When the anesthetic clinical officer arrived and walked into the nurses' station, the officer communicated with the staff with a raised voice. He declared to the nurse technician that the patient should have been referred as they did not have the facilities to monitor her after delivery.

Joshua informed me that Loveness will have to travel by public transport as there was no fuel for the ambulance and she could not afford a private car. Giles came to write the referral, approximately 24 hours after her eclamptic fit. He asked Joshua for Loveness's notes and some paper; he was given paper from an old cotton wool packet. He wrote the referral note. I could see that after a normal blood pressure was taken yesterday, no other blood pressure monitoring was performed until this morning. After receiving the referral note, the patient and her guardian left the hospital to find public transport.

that there were less staff to perform essential duties which meant staff felt that "I'm on my own and very tired" (district hospital midwife).

The staff have frequent contact with donors, which may include nongovernmental and governmental (but not Malawian) organizations or philanthropic organizations or individuals. For individuals, donors provide an opportunity for gaining knowledge and skills and time away from clinical work. However, the actions of donors are not always focused on local needs; for example, a donation of thermometers calibrated in Fahrenheit rather than Celsius can cause confusion.

When the social order is disrupted, the way it was embedded into the context described above becomes apparent. A donor-supported government program equipped a ward to deliver breathing support to neonates (continuous positive airway pressure [CPAP]). However, there were frequent blackouts and no generator. The staff found this distressing and were unsettled during blackouts if they had babies on CPAP. They believed that because of blackouts and because there was no generator, babies were dying. The downstream effect of this was a reluctance to commence CPAP.

This level of distress was at odds with their attitude to other obstacles. For example, they did not have enough water for handwashing or sufficient pain medications for women. However, these events were everyday occurrences and were considered part of their usual work experience. The new CPAP intervention disrupted their environment, and there were neither the rules nor the precedent to dictate the reaction they should have. Therefore, the staff fell back on their instincts and were upset and distressed.

Further illumination of the social order comes from when staff attended training courses, workshops, or campaigns, which were run by donors and nongovernmental organizations. This had 2 effects. First, they removed staff from patient care for the duration of the course. For example, in the community hospital, the clinical officers (who deliver medical care but are not doctors) could be at workshops, which may be unrelated to their roles, for several days. This meant that they were not available to provide care at their hospitals, and therefore, women had to travel for their cesarean delivery. This referral could not be supported by the hospital as there was no fuel for the ambulance.

Secondly, the workshops, could entrench the rules of the hospital and the precedents underpinning the social order. This may happen because staff wanted to attend courses to gain new skills and generous allowances. More seniority meant more workshops, which more junior staff aspired to attend. The more junior staff discussed the unfairness and lack of opportunity, which fostered a determination to move up through the social order.

We have described how the social order of the hospital was related to the way staff interacted with their environment. Loveness's case provided an important window into these contextual issues. She was acutely affected by the lack of infrastructure to enable clinicians to refer or transport her or other patients to referral hospitals; moreover, there were inadequate resources for treatment locally.

So many processes: from the health system to an individual's way of doing things

The hospital operated through several processes and systems. At the "health systems" level, the Ministry of Health created systems that affected mHCWs. For example, staff had to undergo rotations to different districts, hospitals, and departments to provide care. The nurses reported that they were rotated to any department and that there seemed to be no appreciation of the fact that midwifery requires specific skills. District health officers treated all nurses as equal and therefore rotated the staff independently of their clinical capabilities. This meant that nurses felt that their skills were not appreciated and they felt undervalued. However, the more senior matrons had more capability to influence their postings.

Hospital-level systems existed, such as emergency response and referral systems (Box 3). However, they were often not robust and could break down out for hours, or if there was a lack of

Box 3 Hospital systems

Calling for support in the district hospital: At night, there a nursing officer or registered nurse on call from home. For a woman to be taken to the operating theater, one of these staff had to be called in (unless there happened to be a registered nurse rather than a nurse technician on shift) to review the patient before calling the clinical officer. This meant that there was a process to follow, which could delay the calling of a clinical officer. As they do not sleep at the hospital, there could be significant delays in getting the clinical officer to the hospital, as (even if there was fuel) the ambulances could take some time to pick them up.

Mobilizing the theater team in the district hospital: To mobilize the theater team, the staff called the switchboard. Although this made sense on the surface, they often did not understand the urgency of the situation and failed to call people in a timely manner. Furthermore, the switchboard closed for lunch and was not staffed during the evening or night, which meant that the system broke down out of hours.

Receiving a referral at the community hospital: A lady arrived with her guardian as a referral from a health center. She had not received any treatment and arrived barely able to walk and with minimal medical notes. The nurse did not treat her immediately for eclampsia (although later she was found to have had an eclamptic episode at the health center).

resources (eg, no fuel), these fragile systems did not facilitate good care.

At a ward level, systems supported daily work. For example, at all hospitals, there was daily task allocation, which was an ingrained part of the clinical shift at each hospital. However, there were less effective systems, such as poor tracking of patients and losing notes which wasted time.

Finally, individual systems interacted with the wider systems. For example, in the referral hospital, some mHCWs pre-prepared medications for the medication round. When they did this, they sometimes did not label the medications, and each staff member had their way of doing it. When they completed their medication round, if all their pre-drawn up medications had not been used, they were put into the fridge. A discussion often ensued on the next shift about whether to use these unlabeled medications or not as "it is a waste" to throw them away.

Many systems were affected by the social order of the hospital. Two systematic issues were seen in Loveness's case. First, the lack of feedback to the ward from the morning handover meeting meant that the decision was made to refer her to the central hospital in a confrontational rather than collaborative way. An example of a more functioning system was when the clinical officer went to the ward to write the referral letter to the central hospital because he was responsible for her care.

Delivering respectful clinical care

Taking appropriate "clinical action" was difficult if mHCWs were too busy or did not have the skills or resources. Unwell patients were not prioritized because of the lack of systematic history taking, examination, and monitoring. An example of this was when a woman in the district hospital fainted while she was walking to the postnatal ward, alongside her guardian (family member). After briefly checking her conjunctiva for pallor, the nurse allowed her to continue to the ward. Although the most likely diagnosis was a simple faint, there were other, uninvestigated possibilities, but the ward was busy. Furthermore, once the woman seemed to recover quickly, she was allowed to continue to the postnatal ward supported by her guardian.

Even if the staff did not perform the appropriate clinical assessments, they knew what they needed to do. Because of resources, time, and expectations of the care they should provide, patients often received poor care. However, in the case of the CPAP machines, the staff did not have the required training.

When there were enough staff on the ward, the "skill mix" was often inappropriate. For example, newly qualified nurses worked alone and were treated as experienced members of the team. This sets a precedent of being expected to cope. Furthermore, despite them being newly qualified and practicing for the first time, significant weight was placed on their clinical opinion. For example, a newly qualified nurse in the community hospital explained to the clinical officer that a fully dilated multiparous woman could not deliver and would require a cesarean delivery. He was about to take the woman for a cesarean delivery when in one of our general discussions I asked him how he had arrived at that decision; he explained that it was based on the assessment of the nurse, because they know the women best. He thought about it and went to examine the woman. Having asked her to push twice, he realized that the woman, with appropriate direction, could avoid cesarean delivery. Therefore, the woman went on to deliver less than 10 minutes later.

Some mHCWs identified a need for support or were aware of their limitations. An example was a case of twins at the community hospital. The senior nurse was unwilling to start treatment to deliver the second twin without the clinical officer's input. However, he was away for several hours, so treatment was delayed.

MHCWs tried to give respectful care. In the district and community hospitals, when they were available, the staff used curtains and portable screens. However, frequently, the curtains and screens were not available, especially on the 3-bedded labor ward in the community hospital, and therefore, women were frequently exposed, including to people walking in and out of the nurse's station, which had a window on the labor ward.

Social order pervades clinical care. One example of this is directly relating to the set of rules the staff abide by and how strictly they stick to their task allocation. One day, a very competent and conscientious nurse at the referral hospital identified a patient with high blood pressure. She explained the medications that were required to reduce the blood pressure but did not treat the patient. When questioned, she explained that someone else was responsible for the medication round, so she could not interfere with it. This showed an unwillingness to disrupt the social order.

We have illustrated that the staff were making clinical decisions on the background of the social order, based on the rules of the workplace, which over time had enabled staff to cope with their environment. The case of Loveness showed that the staff knew how to deliver respectful clinical care. However, they missed the opportunity to prevent the eclampsia by not taking immediate action when she arrived. When the eclamptic fit occurred, the team reacted cohesively.

Working "hand in hand": relationships in the hospital

There was a hierarchy, based on cadre. This was illuminated when an experienced nurse technician deferred to a newly qualified nursing officer. A technician at the referral hospital explained that student nursing officers questioned why they should listen to her because "you are just a nurse-midwife technician."

Whether staff sought clinical opinions was related to a hierarchy. For example, nursing officers (degree qualified) felt reluctant to consult clinical officers (not degree qualified) who were lower down the social order. They felt they had to "fail" first. However, as with the twins discussed above, this was not universal.

Social relationships were particularly important at the district and community hospitals as the staff lived out of town. Socializing was central to the working day, and the staff laughed, chatted, and helped each other out, sharing food and lending money.

Relationships with patients and guardians were a cornerstone of hospital life. However, the hierarchical divide meant patients showed deference to the staff. Guardians, who were often close family members, played a central role by emptying bedpans and checking if a woman was bleeding after birth. Many nurses valued guardians, had good relationships with them, and shared their resources (eg, gloves). However, others felt that guardians hindered them. This strained relationships and meant that the energy of the staff was directed at keeping the guardians off the ward.

Throughout relationships, social order prevailed. For example, at the referral hospital during the communal lunch, paid for by the staff themselves, the auxiliaries were expected to cook and ensure that the senior staff had the best food.

The social order was illustrated when considering the relationships between nurses and clinical officers, who have a different set of skills and experience. It was not infrequent that women did not receive care from the appropriate professional at the optimal time. This is because clinical officers were less qualified and therefore lower down the social order than the degree-holding nurses. This meant they were reluctant to change the clinical plans made by nurses, just as the nurses were reluctant to call them.

In Loveness' case, social order was illustrated in the interaction between the anesthetist (clinical officer) and nurse (technician). The dictatorial way he communicated revealed the social order in the ward. He was further up the social order than the nurse technician. To a nursing officer, he may have behaved differently. Box 4 shares some general reflections on Loveness.

Discussion

Principal findings

This ethnography provided a window into the working life of mHCWs in Malawi. The staff navigated a health system that was ill equipped to deliver high-quality care. This was undoubtedly hugely influenced by the context of Malawian healthcare, especially the lack of resources and underinvestment of the health workforce.[22] The daily life of mHCWs is affected by the social order of the hospital. When they are at work, the staff perpetuate the social order by following the rules of the workplace and precedent. This contributes to ensuring that care remains at its most basic. To change this, the social order must be disrupted; however, this may create both uncertainty and more work.

Results

In terms of working life, our findings were consistent with other studies in Malawi and Sub-Saharan Africa, where staff battled with the context in terms of resources,[23] too few staff,[24–26] and fragile systems.[22]

Bourdieu[15] described how the social structure was determined by access to capital. Furthermore, this argument applied the idea that if the rules of the workplace and precedent continued to be followed without disruption, access to capital would become further cemented.

To move the staff away from their learned behaviors, there needs to be something to motivate them toward making new rules and setting new precedents.[27] There are potential areas for change; however, it is important to understand that at the level of personal practice and departmental procedure, changing professionals' behaviors is a slow process.[28]

Clinical implications

More resources are required to deliver high-quality care. However, even with more resources, inadequate clinical care and dysfunctional systems and relationships would continue because of the social order of the hospital. We

Box 4 Reflecting on Loveness's story

Loveness provided a lens into the world of a maternity unit in Malawi. She was unable to receive the care she needed due to the context: lack of an ambulance, lack of equipment to perform her cesarean delivery, and lack of medication. Her case became complicated when she was not seen promptly because the hospital was busy. This was exacerbated by the fact that there was no system to identify her level of clinical need. Only when there was an emergency did the team work together to stabilize her; however, she had minimal ongoing clinical care overnight. Moreover, she had to wait all night in the corridor. When he, who had not been previously consulted, finally arrived, he declared that he would not administer any anethesia. This forced her to get a minibus to town 24 hours later.

We never found out the outcome of Loveness or her baby, but she and her unborn baby were at high risk of poor outcomes. Her case was not unusual. Such cases were undoubtedly difficult for the staff. However, within the social order, they had little power to change these outcomes. To improve their working lives, the staff needed to disrupt their social order and set new rules and precedents, thereby changing the local politics of their hospital. Redefining the social order of the hospital would mean working lives could evolve. Furthermore, maternity healthcare workers could work in a more fulfilling, better supported way, and women could receive the best possible care.

proposed 2 initial solutions, which could be implemented at low cost, but which would require a culture change.

First, the staff could be empowered through a new culture of training, learning, and role modeling by senior clinicians. We would propose a shift from training people away from their hospital at expensive courses toward fostering a culture of in-house learning and development for all clinical staff. These senior clinicians must be empowered to set new precedents through positive role modeling and being present to share their clinical experience rather than relying on models of supervision,[6] which are externally funded and focused on guideline adherence rather than the provision of clinical care.

Second, clinicians must work with health system managers to understand what it means to work as a clinician. This could build the managers' capacity to get the best out of their teams, by ensuring an adequate skill mix.

Research implications

To disrupt the social order and ultimately change the care, complex interventions will need to be developed and tested. Evaluating on a small scale, the effectiveness of a clinical change as suggested above could have a powerful influence on embedding cultural changes throughout a whole health system.

Strengths and limitations

This ethnography took place across 3 sites, and this brought its challenges in terms of depth but allowed ideas to be considered and "tested" in the different settings. To achieve this, only specific elements of the hospitals were observed. In the community hospital, all inpatient maternity services were observed; in the district hospital, antenatal inpatients were not included; and in the referral hospital, the observation was restricted to the high-risk postnatal ward. Interestingly, many of the findings were broadly comparable across sites.

An ethnographic approach provided insights that would not have been possible without this depth of relationship. However, this also brought a potential for bias. The ongoing examination of our position as the research team during data collection and analysis was important, as was discussing the emerging findings with local researchers and healthcare staff. This facilitated the development of a more robust argument. Situating the findings within ethnographic work from Malawi[19–21] has enabled us to identify commonalities and ensure that findings were not at odds with existing work.

Conclusions

Approaches, which focused not only on specific practices of the staff but also on the working environment, culture, and relationships, may help the next generation of Malawian mHCWs to be happier at work and to better provide respectful, comprehensive, high-quality care to women. ■

ACKNOWLEDGMENTS

We would like to thank all the patients and staff at the study hospitals for allowing the observations to take place.

REFERENCES

1. World Health Organization. Trends in maternal mortality 2000 to 2017: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division: executive summary. 2019. Available at: https://apps.who.int/iris/handle/10665/327596. Accessed January 25, 2021.
2. Pot H, de Kok BC, Finyiza G. When things fall apart: local responses to the reintroduction of user-fees for maternal health services in rural Malawi. Reprod Health Matters 2018;26:126–36.
3. Prost A, Colbourn T, Seward N, et al. Women's groups practising participatory learning and action to improve maternal and newborn health in low-resource settings: a systematic review and meta-analysis. Lancet 2013;381:1736–46.
4. Kachimanga C, Dunbar EL, Watson S, et al. Increasing utilisation of perinatal services: estimating the impact of community health worker program in Neno, Malawi. BMC Pregnancy Childbirth 2020;20:22.
5. World Health Organization. Standards for improving quality of maternal and newborn care in health facilities. 2016. Available at: https://www.who.int/docs/default-source/mca-documents/advisory-groups/quality-of-care/standards-for-improving-quality-of-maternal-and-newborn-care-in-health-facilities.pdf. Accessed October 20, 2017.
6. Avortri GS, Nabukalu JB, Nabyonga-Orem J. Supportive supervision to improve service delivery in low-income countries: is there a conceptual problem or a strategy problem? BMJ Glob Health 2019;4:e001151.
7. Cheshire J, Jones L, Munthali L, et al. The FAST-M complex intervention for the detection and management of maternal sepsis in low-resource settings: a multi-site evaluation. BJOG 2021;128:1324–33.
8. Merriel A, Dembo Z, Hussein J, et al. Assessing the impact of a motivational intervention to improve the working lives of maternity healthcare workers: a quantitative and qualitative evaluation of a feasibility study in Malawi. Pilot Feasibility Stud 2021;7:34.
9. McAuliffe E, Daly M, Kamwendo F, Masanja H, Sidat M, de Pinho H. The critical role of supervision in retaining staff in obstetric services: a three country study. PLoS One 2013;8:e58415.
10. Hammersly M, Atkinson P. Ethnography. 3rd ed. Routledge; 2007.
11. Emerson R. Writing ethnographic field notes. 2nd ed. Chicago, IL: University of Chicago Press; 2011.
12. Bazeley P. Qualitative data analysis. London, England: Sage Publications; 2013.
13. Miles MB, Huberman AM. Qualitative data analysis: an expanded sourcebook. Thousand Oaks, CA: Sage Publications; 1994.
14. QSR International Pty Ltd. (2014) NVivo (Version 10), https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home
15. Bourdieu P. The forms of capital. In: Richardson J, ed. Handbook of theory of Research for the Society of Education, Westport, CT: Greenwood Press; 1986:241–58.
16. Bourdieu P. Distinction: a social crititue of the judgement of taste. Cambridge, MA: Harvard University Press; 1984.
17. Bourdieu P. The logic of practice. Stanford, CA: Stanford University Press; 1990.
18. Bourdieu P. The social space and the genesis of groups. Theor Soc 1985;14:723–44.
19. Sikstrom L. "He is almost like other children": an Ethnography of Malawi's National Pediatric HIV Treatment Programme. 2015. Available at: https://central.bac-lac.gc.ca/.item?id=TC-OTU-71621&op=pdf&app=Library&oclc_number=103319590. Accessed November 20, 2016.
20. Anders G. In the Shadow of Good Governance: an Ethnography of Civil Service Reform in Africa. Netherlands, Europe: Brill; 2010.
21. Wendland CL. A heart for the work. Chicago, IL: University of Chicago Press; 2010.
22. Chen L, Evans T, Anand S, et al. Human resources for health: overcoming the crisis. Lancet 2004;364:1984–90.

23. Kinney MV, Kerber KJ, Black RE, et al. Sub-Saharan Africa's mothers, newborns, and children: where and why do they die? PLoS Med 2010;7:e1000294.
24. Kruse GR, Chapula BT, Ikeda S, et al. Burnout and use of HIV services among health care workers in Lusaka District, Zambia: a cross-sectional study. Hum Resour Health 2009;7:55.
25. Muula AS, Maseko FC. How are health professionals earning their living in Malawi? BMC Health Serv Res 2006;6:97.
26. Rowe AK, De Savigny D, Lanata CF, Victora CG. How can we achieve and maintain high-quality performance of health workers in low-resource settings? Lancet 2005;366:1026–35.
27. Deci EL, Ryan RM. The "what" and "why" of goal pursuits: human needs and the self-determination of behavior. Psychol Inq 2000;11:227–68.
28. Grol R, Grimshaw J. From best evidence to best practice: effective implementation of change in patients' care. Lancet 2003;362:1225–30.