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The Midwifery Practice Challenges in the Rural Populations of Indonesia

Indrayani, Farid Husin, Amida S. Sarbini, Ari Andriyani, Dewi N. Sari,
Fitrina Bachtar, Mardiani Bebasari, Meilinda Agus, Sitti Mukarramah,
Mutiara R. Suseno, Raihanna Norfitri and Yunita Marliana
Bina Husada Midwifery Academy, Jl. Kutai Raya No. 1,
Bencongan Kelapa Dua, Tangerang, 15811 Banten, Indonesia

Abstract: The increasing rate of infant and maternal mortality has required that the government put specific measures in place to decrease it. Placing midwives in villages with the aim of raising the quality of health care, distributing health services more effectively and to attempt to reduce infant and maternal mortality rates. Many problems were faced by village midwives impact to the non-optimal performance of them. This study is aimed at identifying the obstacles faced by midwives in villages as practitioners and the basis in the revision of village midwives program, in the hopes that midwives in villages would be able to contribute more effectively to reducing maternal mortality rates in the future. Twenty two individual in-depth interviews were conducted in villages across six provinces in Indonesia from November to December 2013. The study explored the obstacles faced by village midwives in midwifery practice. There are many problems faced by village midwives in rural Indonesia such as autonomous midwifery skills, age and appearance, language and communication, licensing practice management, understanding of promotion, authority, workload, facilities and infrastructure, geographical factors, compensation and reward, traditional birth attendant and social tradition. The village midwife program is an effective strategy in reducing infant and maternal mortality rate but not the optimal role of educating and producing graduates and healthcare professionals. In making appropriate regulation, the government's placement and monitoring of the performances of village midwives has had an impact on a previously non optimal role of village midwifery.

Key words: Village midwives, obstacles, rural area, distributing, identifying

INTRODUCTION

Health development is focused on improving community health status. Equitable health services are one such effort to reach the communities and improve their health status. However, the difficult geographical conditions make providing health services to remote areas difficult. To overcome this problem, the government launched a midwife program which placed midwives in rural areas that are difficult to reach. Midwives are the nursing staff who have the duty to provide health services in rural communities. The program involving village midwives aims to ensure that pregnancy and childbirth are safe for all pregnant women (Makowiecka *et al*., 2008; Shiffman, 2007; Hull *et al*., 1998). Village midwives are responsible to the head of public health centres and research in collaboration with the village apparatus. The midwives in villages are responsible to the chief of public health centres in such places and collaborate with the apparatus in the village. Midwives, who have been placed are obliged to stay and have the obligation to provide health care services to rural communities.

The results of the analysis carried out for >20 year has shown that midwives contribute significantly to meet the needs of even distribution of health services, especially where public indifference based on income is low, cultural traditions, health status or location (Clawson and Osteweis, 1993). However, until now the village midwife program is still considered not the answer to the problem of high rates of maternal and infant mortality. Low quality, the difficulty of access and inaccessibility to primary health care continues to be a problem for rural areas and specific populations in several countries (Miller, 1993). Any incompatibility of the ratio between the number of villages, population and land area with the number of midwives in villages that have impacted workload must be borne by the village midwife. There are still many problems which are faced by midwives that have not been identified yet. This study is aimed to identify the obstacles of midwives in villages as a practitioner and the basis in the revision of village midwives program with the hope that midwives in villages would be able to contribute to reducing maternal mortality rate in the future.

Corresponding Author: Indrayani, Bina Husada Midwifery Academy, Jl. Kutai Raya No. 1, Bencongan Kelapa Dua, Tangerang, 15811 Banten, Indonesia

Table 1: Characteristics distribution of participants

Participant characteristics	Amount
Age (years)	
≤20	1
>20-30	11
>30-40	8
>40-50	2
>50-59	0
≥60	0
Education	
Diploma	22
Bachelor degree	0
Master degree	0
Officiate period (years)	
2-4	6
>4-6	10
>6-8	4
>8	2

MATERIALS AND METHODS

The design of the study was a qualitative phenomenological approach. Data collection in this study was conducted from November to December 2013 in villages across six provinces in Indonesia such as West Sumatera, South Sulawesi, West Java, Yogyakarta West Nusa Tenggara and South Kalimantan. The samples in this study were selected by purposive sampling techniques. Participants chose to give descriptions of obstacles faced by midwives in performing all their responsibilities. The participants recruited in this study were 22 midwives in the rural area. In detail, the characteristics of participants can be seen in Table 1.

Data collection: Data was collected through in-depth interviews with selected participants using an interview guide. In-depth interviews were conducted individually and focused upon investigating the personal experiences of each participant. In-depth interviews conducted after the interviewer explained related information to the study and after the informant gave consent (informed consent), including approval to use a tape recorder. In-depth interviews conducted with the use of Indonesian and/or local language in each province with reference to the interview guide. Interviews between 30-45 min took place both at the volunteer's home and at a health facility. All interviews were tape recorded and fully transcribed. All recorded audio interviews were transcribed to Indonesian by the interviewers. Transcription results were cross-checked with those of recorded audio done by the research team and then sent to the core researchers in the province of West Java for further analysis. For each transcription, topics related to the research objectives were identified and coded. Once coding was completed, the theme was developed and classified with reference to the previously described framework.

RESULTS AND DISCUSSION

Autonomous midwifery skills: Obstacles faced when working directly with the community were the key difference, in theory, practiced on campus from those in the field; lack of practical experience gained during education strongly suggested that after graduation they have no confidence to work autonomously.

After graduation and research, I have dared to help during childbirth by myself, I just saw the seniors only, because of fear, distrust and lack of practical experience. I'm confused, especially if you've faced pathological cases such as hypertension, breech, gemeli pregnancy and so on. Confused about what to do because in college I only wrote theories, no simulation case.

Age and appearance: The majority of young midwives with no work experience who are placed in villages may cause more problems to the midwives village program. Midwives were not trusted by people because they were judged immature, self-carriage midwives are less flexible, have no experience of giving birth thus a new midwife is often underestimated and not trusted by the public. Attitude adjustment within the society, the gap between the senior and junior with competition against Traditional Birth Attendants (TBA's) and inability to be a mediator between husband and wife or husband and wife with other family members while most young midwives who were placed in the village were not married and got confused easily. People prefer to believe old and experienced TBA's compared to midwives who are still very young and inexperienced.

Keeping up with the traditional birth attendant, when I am called for deliveries in houses, upon arriving I could see traditional birth attendant already did my job because my appearance was still considered like a "little girl" compared to the traditional birth attendants who were already experienced, sometimes they were not cooperative and seemed somewhat underestimating, although not all.

Technology: As time goes on, science continues to evolve. The evaluation of the efficacy and safety of care continues to be sustained through research. Therefore, midwives should be updated in midwifery sciences, so they can practice safely. Advances in technology have a major impact on health development, including ease of information access provided from various parts of the world. Many scientists who did research publish it on the internet. To access the research report, midwives need to have access to computers and the internet. This can assist the midwife to have easy access to the latest research reports online. However, the state is not in line

with the findings in this study that shows nearly all village midwives did not have the necessary skills to use computers and access the internet. All the village midwives in the study claimed to never have access to scientific sites on the internet. Sites they often use are social media sites such as Facebook, Twitter and Instagram.

I cannot operate the computer, let alone have access to research reports. Nevertheless, I often use Facebook and Twitter.

Language and communication: Language is a medium of communication that is very important to the success of communication. Many complex problems can be resolved with good communication; otherwise many problems may arise due to miscommunication. The obstacles faced by rural providers are mainly language problems. Most rural communities use local languages as the language of everyday life, thereby making the rural society unable to understand the Indonesian language. A large majority of midwives only understand Indonesian and don't understand the local language; this condition affected and caused a bad relationship between midwives and their communities because of miscommunication.

Rural communities generally uphold the tradition or culture of the region. Most of them do not understand Indonesian and there are midwives who are not familiar with the local language, so sometimes misunderstanding happens. If we use the local language, they will be more familiar to us.

In addition, most of the participants also acknowledged their lack of ability to communicate and interact with the community, advocacy and negotiating capabilities (with community leaders, cadres and TBA's) as long as they got college practice; they got more practice at hospitals and independent midwifery practice and less within the community.

The ability that I feel is very, very inadequate especially for poor communication skills among others. I do not know how to interact with community leaders or negotiate with the local government, cadres and traditional birth attendant. It is also about the local culture and how to change the culture of the community that is detrimental to health.

Licensing practice management: Providers reported experiencing confusion when they open practices independently. They do not understand the mechanisms in the management of independent midwives practice as those midwives are only taught in colleges in theory, they are not introduced to the flow or management mechanism and how the proposal form works.

I would like to open practice wondering how to take care of it, what were the requirements, how was the shape of the form and filling it for, during college, I just received theoretical knowledge. There should be shown examples of the form, how to fill it and other necessary files for the establishment as well as how to choose the right location.

Understanding of promotion: Midwives who practice independently reported experiencing problems in promoting their clinic. In addition, they are also less knowledgeable in financial management.

I didn't know how to promote my clinic practice. I found information by myself about the tricks and the promotion ways from others friend who opened clinic practice.

Authority: The amount of work to be done by village midwives is not in accordance with their authority. Public demand for midwifery graduates is very high; people also did not realise or seem concerned by the limits of a midwives authority. A midwife should also be able to handle accident cases, circumcision and general health treatments. The public does not even want to know, whether it is the authority of the midwife or not, they only know that midwives are health workers who have multiple functions.

This is bitter sweet as I worked as a midwife. The bitter part is when I refused the treatment of common patients with malaria pain, cough and illnesses, many patients even my own midwife friends mock me and they say "how can a diploma 3 midwifery graduate not prescribe medication?"

There is a regulation forbidding midwives to help patients at home. It becomes a dilemma in itself for the midwife in rural communities. Generally, patients prefer to deliver at home, in the end, they prefer to deliver with the aid of a TBA due to home birth.

I am so completely confused because of the rules, midwives attending births should not be in the house while the community tradition here prefers to deliver at home. Some of my patients say "I actually want to give birth with a midwife but my in-laws want a home birth because it has become a tradition in our family. In addition, home birth is more soothing because you are surrounded by people we know. Therefore, I decided to give birth using a traditional birth attendant".

Workload: All village midwives complain about the work burden they have to bear. They are charged with additional tasks outside their main duties as a midwife. This is often the cause of the abandonment of their main duties as a midwife.

I was shocked when I first knew my job because what I had in mind was that a midwife's job is confined to the provision of health minister regulations governing

permissions and organizing midwife practice. I could not focus on my main task as a midwife because I had to do additional tasks... moreover, there are stacks of reports I should finish... Sometimes I got reprimanded because of suboptimal work. But eventually, I finished the low-quality report.

Facilities and infrastructure: There are infrastructural obstacles faced by midwives, including limitations of equipment and medicine for practice as well as electricity thus they cannot use technology such as Doppler obstetrics devices because of the absence of electricity for charging and their remote locations. Moreover, the demand that midwives must live in the village while the shelter provided is uninhabitable, forcing them to rent or share local resident's homes.

When I was working in a remote village I was immediately given a place to stay but after seeing its condition, the place was totally below standard for habitation.

Geography: The vast areas and varied geographic conditions became an obstacle for the midwife to get to resident's homes and vice versa, the residents themselves find it hard to reach the midwife due to the distances involved and extreme road conditions they face in getting to the midwife.

Sometimes, midwives have to face challenging journeys in order to provide services to the public. More patients home are difficult to reach; we are forced to walk or a combination of walking and boarding vehicles. This means that for half of the journey, we use motorcycle/vehicle and the other half on foot.

Compensation and reward: The entire provider reveals the incompatibility of compensation received by the midwives, considering the workload they have to bear and the absence of reward obtained by village midwives.

The sad part is when you have to walk from one village to another, you must travel many kilometres, after the service we are paid with banana and peanuts but we are still happy because this is the struggle as a midwife.

Traditional birth attendant and society tradition: Obstacles faced by informants in rural areas are public confidence in the tradition/culture of delivery assistance by TBA's because there are rituals which must be upheld, both during and after the process of childbirth.

Some people here strongly believe the regional cultural beliefs... to be honest I do not understand the culture of the area in depth here... so some of them prefer more the traditional birth attendant. It is said that there are rituals that must be followed and should not be broken... the traditional birth attendant understands those habits and rituals.

Many obstacles faced by midwives cannot be separated from the weak role of education in producing graduates of professional midwives. There is a gap between education and the job market. The job market needs soft skills more than hard skills. The lack of soft skills and hard skills are things that desperately need to change within the job market. The ability of midwives in midwifery care is largely determined by the learning experience that they get during college education. Student midwives received clinical learning experience in independent practice midwifery, public health centres, hospitals and communities. However, the practical experiences gained in the community by the student midwives generally are not specific to the real work of the midwife. Work such as data collection, mapping the area, transect, search the root of the problem and the village community meetings. Midwife students practice in urban areas more than rural areas. Midwifery educational establishments are not aware that the opportunities for midwives to research in urban areas are less than in rural areas. In rural areas, the ratio of primary health care providers are less in urban areas (Hanson, 1992; O'Neill *et al*., 1993) and the ratio of midwives in the rural area more than doctors (Lin *et al*., 1996). There is a stack of reporting that should be done by village midwives, it makes the midwives feel shocked and unable to do the entire work of the village midwife because they never get to experience how village midwives work. A Southern England study shows that during education the students can feel inadequate in preparing themselves for the real task of midwives in the field (Chamberlain, 1997). Therefore, there is a need for midwifery education to undertake various repairs in education to prepare graduates to be able to work in all circumstances, including in very remote villages. Mapping and identification of gaps in the field are required for the development and improvement of the midwife competences. Nevertheless, the problem does not only contribute to midwifery education but also to the regulation of health professions. Health professions regulation affecting the provision and distribution of midwives to reach underserved populations, (Mittelstadt, 1993; Safriet, 1992) while the government contributes towards hindering the success of the village midwife program by appearing less selective in the choosing of a midwife to be placed in the village. There is no clinical work experience required to become a village midwife. Generally, midwives who are stationed in the village are of a young graduate age and often inexperienced. The prior

study proves that the duration of working as a midwife will provide a lot of experience for midwives, the experience would affect the performance of the services provided to the public as they will be more efficient and effective. The midwife in the village has more authority than the midwife in urban areas, add the absence of a clear job description of village midwifery and the lack of performance of the village midwives is often compounded by the many reports that must be prepared by the midwife every month. The severity of the workload borne by village midwives renders them unable to work optimally. The absence of a clear job description for the village midwife makes them face many problems. Many tasks are delegated to the village midwife and this makes them become unfocused with their main task as a village midwife. The results of 2002-2003 National Health Survey showed that the workload of midwives in the village is still quite heavy because they handle more than one village (MHIM, 2003).

Therefore, the village midwife who will be deployed in rural areas should get prior training to be able to perform their function as a village midwife. However, a good competence becomes unused if it is not supported by adequate facilities and infrastructure. The prior study showed that increasing the number of midwives, generally did not match with the improvement of the facilities and infrastructures. The problem makes the midwives unwilling to be placed in villages so that there are more midwives to choose to work within the public health centres as opposed to the villages. Many buildings used as village maternity posts are not feasible or their condition is badly damaged, moreover, there may be villages which do not have a building fit to be utilised as a village maternity post. In addition, there is no adequate equipment for midwives, electric, facilities, etc.

Facilities that are not available in 24 h moreover, there are villages without electricity, it is difficult to get clean water, so many midwives choose not to stay in the village (Kristiani, 2013).

Other issues have been found, although health facilities and health professionals have been available in the village but people prefer maternity assisted by paraji. (Heywood and Harahap, 2009a, b) the low level of education of rural communities affects their decision making. Caldwell (1979) and Mrisho *et al*. (2007) express that the educational levels of people in the rural areas causes their inability to seek health services appropriately. Not only that, tradition and culture which is upheld by people in the rural areas makes them trust TBA's more than health providers. This statement is in line with the Chiarella study which found that midwives faced with challenges related to the lack of cultural sensitivity and inability to reflect the complexity of care. The same findings were evident in the Amilda and Palarto (2010) study that people prefer to utilise traditional birth attendants much more than midwives with consideration to traditions in their village who had always given birth at home, supported by TBA's. The statement was supported by a high rate of utilization of the TBA's (30%) and home deliveries (55%) in rural communities (National Family Planning Coordinating Board, 2008). The women believe that to deliver their baby at home is more convenient because of their responsibility towards children or other household members (Titaley *et al*., 2010). The big reason for women who prefer TBA's is because they want to deliver their baby at home surrounded by people they are comfortable with. This is consistent with results of previous studies that revealed that one of the factors that can hinder people's access to better primary care is the regulatory and professional environment that hinders health professionals to provide care completely and their preparations are typically much more stringent than that required for the protection of society (Safriet, 1992; Welch, 1991; Pearson, 1996; Kany, 1995).

The role of village midwives and TBA's were considered vital, especially in rural areas where health care is not optimal. Since 2007, Government has also made an anticipatory action, by initiating a partnership involving the village midwives and TBA's through an improving maternal health program in Indonesia. In this scheme, village midwives and TBA's are expected to co-operate in attending births. TBA's are expected to provide services including herbal drinks or post-natal care, while all medical care must be provided by a midwife. However, the implementation of the partnership program between midwives and TBA's varies throughout the different villages (Titaley *et al*., 2010; UNICEF, 2016).

CONCLUSION

The village midwife program is a good strategy in reducing infant and maternal mortality rate but not the optimal role of education in producing graduates and healthcare professionals in making appropriate regulation and government in the placement and monitoring of the performance of village midwifery impact on the optimal role of village midwives. Furthermore, it is necessary for midwifery education to evaluate and improve the education curriculum based on the competencies required, mapping the job market to the formulation of the competence of graduates. The need for improved regulation that can directly support the work of village midwives. It needs a placement test on candidates for village midwives, monitoring and evaluation of the performance of midwives to ensure the effective and successful implementation of the village midwife program.

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