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Vietnamese midwives' experiences of working in maternity care – A qualitative study in the Hanoi region

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ABSTRACT

Objective: This study aimed to explore Vietnamese midwives' experiences of working in maternity care.
Methods: A descriptive qualitative study was undertaken, which involved four focus group discussions with midwives (n = 25) working at three different hospitals in urban, semi-urban and rural parts of Hanoi region, Vietnam. Data were analysed using qualitative content analysis.
Results: The overall theme, "Practising midwifery requires commitment" showed that Vietnamese midwives' dedication to their work and to women's reproductive health helped them to cope with stress, pressure and negative aspects of their work environment. In the first category "Being the central link in the web of care", midwives described themselves as having a key role in maternity care although collaborations with other health professions were important. In the second category "Rewarding role but also vulnerable position", positive aspects of midwifery were expressed although the great pressure of the work midwives do was prominent. High workload, patients' demands, and being negatively exposed and vulnerable, when adverse events occurred, were reported. In the third category "Morally challenging tasks", ultrasound examinations to reveal fetal sex and working with abortion services were described as emotionally stressful.
Conclusions: Although participating Vietnamese midwives experienced midwifery as essentially positive, they felt exposed to significant workload pressure, ethically highly demanding work and being blamed when adverse obstetric events occurred. Public health interventions to inform Vietnamese citizens about reproductive issues, as well as specific antenatal education measures may increase the understanding of evidence-based maternity care and complications that can occur during pregnancy and birth.

Introduction

Midwifery care is key to improving sexual, reproductive, maternal and newborn health. In order to accelerate reduction in morbidity and mortality among women and babies in low and middle income countries, there is a need to increase the midwifery workforce and improve their working conditions [1]. Due to the nature of the work, midwifery can be emotionally challenging as it deals with birth and death, including moments of both joy and sadness, as well as physical and emotional pain [2]. Internationally, midwives experience different kinds of work-related psychological distress including occupational and organisational sources of stress [3]. High workload due to low staffing levels, lack of continuity of carer, low support from colleagues, challenging clinical situations and low levels of clinical autonomy, are all found to be correlated with poor emotional wellbeing among midwives [4].

Abbreviations: FGD, Focus Group Discussion; HMU, Hanoi Medical University; SRB, Sex Ratio at Birth; WHO, World Health Organization.

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Although involvement in abortion services may form part of midwives' duties, some midwives encounter moral, practical, religious or legal reasons for declining to perform abortions on the grounds of conscience [5]. Furthermore, workplace violence is experienced worldwide by one in five healthcare professionals annually [6], and this has also been reported as an issue in Vietnam [7]. Work-related burnout symptoms have been reported as common among midwives and may be exacerbated by exposure to workplace violence [8]. A systematic review and *meta*-analysis found a 40% prevalence of work-related burnout among midwives [9]. Approximately one fifth of midwives in Europe and Asia have considered leaving the profession and every third have considered leaving the organisation [10]. Fewer years in practices, poor or stressful work environment and insufficient organisational support are some of the factors linked to burnout among midwives [11]. Important retention factors among midwives have been reported as career development, promotion and appreciation of their work contribution [12]. Midwives report better job satisfaction and are found to be more inclined to stay in their jobs if they are able to build a relationship with the pregnant woman in their care, have the ability to work in a caseload continuity of care model, are well supported by their managers [9], and have a good relationship with colleagues [13].

Reproductive health in Vietnam

Vietnam's health indicators have improved significantly over recent decades and the country has been classified as a lower middle income country since 2010 [14]. In 2019, there was an estimated total fertility rate of two children per woman and the maternal mortality ratio was 46/100 000 live births [15]. Most pregnant women (90.7%) in Vietnam receive at least three antenatal care visits [16] and there is a widespread use of obstetric ultrasound [17]. The great majority (98.5%) of all births was assisted by a skilled attendant in 2018 [16]. Maternity care is provided at commune-, district-, provincial- and central levels in Vietnam [18]. In addition, the private sector co-exists with public services, and private healthcare is seen as a resource to increase healthcare coverage [19]. Compulsory social health insurance covers the cost of public pregnancy and delivery care at lower level healthcare facilities, with referral to higher level hospitals in case of complications during pregnancy and birth [20]. This care in the public system is provided to women free of charge. Due to the perception of higher quality of health care and increased access to more advanced technology at higher level hospitals and at private hospitals, many pregnant women in urban areas pay out of pocket to get direct access to these facilities [21]. Midwives are available in almost all hospitals and commune health stations, however physicians are the main providers of antenatal care, and most births take place in hospitals assisted by physicians. In Vietnam, abortions are legal up to 22 weeks of gestation [22]. In East and Southeast Asia the estimated abortion rate was 43 per 1000 women (aged 15–49 years) between 2015 and 2019, however reliable estimates for Vietnam are lacking [23]. In 2015, more than 270,000 abortions were reported from public health facilities [24], and an additional 89,000 abortions are estimated to have been performed in the private sector [22]. Fetal sex diagnosis and sex selective abortions have been prohibited in Vietnam since 2003 [25]. Despite this, the sex ratio at birth (SRB) was reported as 111.5 boys per 100 girls in 2019, which far exceeds the biological level of 105–106 males per 100 female births [26]. The sex ratio imbalances seen in Vietnam have been attributed to widespread son preference and the practice of prenatal sex selection. Laws prohibiting the practice in Vietnam, including determination of fetal sex, have not been effective in reversing the trend [27]. The overall prevalence of caesarean sections is reported to be approximately 29%, although the rate differs significantly between urban (42%) and rural areas (23%), and also between different socio-economic groups [28].

This study is a part of the CROss Country UltraSound study (CROCUS), exploring midwives' and obstetricians' experiences and views of obstetric ultrasound in six different countries. The CROCUS study also includes investigation of aspects of health professionals' roles and ethical aspects of maternity care. Midwives have a key role in improving maternal and newborn health and there is a great need to scale up the midwifery workforce [1]. Little is known however about Vietnamese midwives' experiences of their work in Vietnamese maternity care. The aim of this study was therefore to explore Vietnamese midwives' experiences of their work in the Vietnamese maternity care system.

Methods

Study design

Framed in a naturalistic paradigm [29], a descriptive study was undertaken, which involved focus group discussions (FGDs) with midwives working in Vietnamese maternity care. Data were analysed using qualitative content analysis.

Study setting and participants

Health facilities in urban, semi-urban and rural parts of the Hanoi region, Vietnam were purposively selected for recruitment of midwives as participants. The participants were recruited from three public hospitals, one hospital from each of the district-, provincial- and national levels, to gain a broad range of Vietnamese midwives' experiences. Recruitment of participants was organised by the local member of the research group (Author 2) who contacted the heads of the Departments of Obstetrics and Gynecology at the selected hospitals, and they all approved participant recruitment. A coordinator, appointed by the head of each Department, was informed about the study by Author 2 and assisted with the recruitment. Diversity was sought in relation to midwives' age, work experiences and duties in maternity care. Participants were recruited from antenatal, delivery and postnatal wards. On the day of data collection Author 2 informed all available midwives at the Department about the study and the voluntary nature of participation. A total of 25 midwives participated in the study, with 6–7 participants in each of the four FGDs. None of the available midwives declined participation in the study. The participants were offered a small remuneration after the interview in line with customary practice in Vietnam. Participant characteristics, including age, education and length of work experience as a midwife, were collected before the start of each FGD (Table 1).

Data collection

Data collection was performed at the participants' workplace, i.e. the selected hospitals, in March 2013. The FGDs were moderated by a Vietnamese medical doctor (Author 2) experienced in qualitative research and with work experience from the local setting, and all FGDs were conducted in Vietnamese. Two other members of the research team (Author 5 and 7) participated as observers together with a male Vietnamese-English interpreter who enabled the non-Vietnamese speaking observers to follow the discussions. The participants, the moderator and the observers were all females. A thematic interview guide, previously used in other CROCUS studies, served as the basis for the FGDs. The interview guide included questions regarding obstetric ultrasound [30] but also questions about a) midwives' role in relation to other occupational groups, b) positive and negative aspects of working as a midwife and c) other issues of importance that the midwives wanted to bring up for discussion. Aspects related to the use obstetric ultrasound have been reported in a previous publication [30]. This paper describes the rich data set that the participating midwives provided related to their professional role and their working conditions.

The FGDs were audio-recorded and lasted approximately 60–70 min. Field notes were taken by the observers. After each FGD, the moderator and the observers discussed the content of the discussion.

Table 1
Characteristics of the participating Vietnamese midwives.

FGD	No. of participants	Hospital area	Age, mean years	Age, range years	Work experience, mean years	Work experience, range years
A	6	Urban	42.5	33–47	19.8	12–24
B	7	Urban	31.3	27–42	9.3	4–20
C	6	Semi-urban	31.0	25–40	10.8	4–20
D	6	Rural	31.5	27–39	8.9	1.5–15
All	25		34.4	25–47	12.1	1.5–24

Data analysis

The FGDs were transcribed verbatim by Vietnamese staff at Hanoi Medical University (HMU). The moderator (Author 2) proof-read the transcribed text while simultaneously listening to the audio-recordings of the FGDs. In the next step, the transcriptions were translated from Vietnamese to English by staff at HMU, and the moderator systematically checked the quality of the translation. The FGDs were manually analysed using qualitative content analysis informed by Graneheim and Lundman [31]. First, two of the authors (Author 1 and 7) read the transcripts several times to get a sense of the whole. The first author (Author 1) identified the meaning units and labelled them with a code. In the next step, codes related to each other were discussed and organised into sub-categories and categories (Author 1 and 7). The preliminary results were thereafter reviewed by the moderator (Author 2) and minor adjustments were made. At the end of the analysis process a theme was formulated reflecting the underlying meaning of the data overall. Finally, all authors reviewed the analysed content and discussed the findings until consensus was achieved. Examples of the process of analysis is presented in Table 2.

Ethical considerations

This study was approved by the Ethical Board at Hanoi Medical University (HMUIRB) in Bio-Medical research (reference 141/HMU IRB). All methods were carried out in accordance with relevant guidelines and regulations. Eligible midwives were provided information verbally that participation was voluntary and could be halted at any time. Written and verbal informed consent was obtained from all participants before commencing data collection. All data are presented on an aggregated level and personal identifiers have been removed in the quotations in order to protect the privacy of the participants.

Results

Three main categories and seven sub-categories were derived from the materials (Table 2). The overall theme, "Practising midwifery requires commitment" was formulated during analysis. This theme reflects the midwives' dedication to their work and to women's reproductive health, something which helped them to cope with the stress, the pressure and the negative aspects of their work environment. Yet the midwives were challenged by the continually changing nature of the work they performed and the need to be always alert and flexible. This was particularly the case when patients were dissatisfied or the tasks were perceived as morally demanding. The participating midwives enjoyed many aspects of their work, although some questioned whether it was worth the pressures they were exposed to.

Being the central link in the web of care

Midwives play a key role in a hierarchical maternal healthcare system

Midwives were reported to play a very important role in maternity care from the beginning of pregnancy, throughout labour and postnatal care. Although the work of nurses and midwives was to some extent overlapping, midwives reported that the work of nurses was different, as midwives had greater responsibility for patients.

Table 2
Description of the process of analysis.

Examples of meaning units*	Code	Sub-category	Category
Midwives are in charge of many things in antenatal care, from the start of pregnancy until the birth	Midwives in charge throughout pregnancy	Midwives play a key role in a hierarchical maternal healthcare system	Being the central link in the web of care
Our goal is to make patients understand the counsel we give	Individual counselling	Counselling is an important part of antenatal care	
We enjoy the happiness that the work brings us, but it passes by very quickly	Happiness passes quickly	Mostly exposed to pressure but also experiencing joy	Rewarding role but also vulnerable position
In fact, when an accident happens, we are all blamed for the accident	Blamed for accidents	Feeling unfairly blamed for adverse events	
They don't tell patients directly the gender of the baby, but they often say that the baby is like the mother or like the father	Reveals the gender in an indicative way	Double standard for sex determination and pronounced preference for sons	Morally challenging tasks
She did not want to work there [abortion services], not because she did not want to work, but because she was emotionally challenged by the ethical issues	Abortions give rise to ethical issues	Emotionally stressful to work with abortion services	
The hospital decided to establish the caesarean section service area to serve the patients 'on request'	Service area for non-medically indicated caesarean sections	Caesarean section on maternal request	

* Original statements from the text

"To be frank, midwives' responsibility is much heavier [than nurses]. *Midwives have to do more work and participate in treatment as well as take care of patients directly."* (FGD A)

Collaboration between health professionals was explained as important to ensure the best healthcare for the patients. Midwives and physicians were reported as having independent roles but with close collaboration with each other.

"Doctors, nurses and midwives do different things, but we collaborate to ensure the safety of patients…" (FGD A)

Although the midwives respected the physician as the final decision maker, they reported that they could provide suggestions to the

physician on how to manage the pregnancy. Physicians were generally reported as having great trust in experienced midwives, however it was also said that some physicians did not pay attention to suggestions by midwives.

> *"Experienced doctors take our advice and the patients can be cured. But some doctors are so conservative, they think that their educational level is higher than ours, they somehow look down on us, they don't care about our advice. But we still have to respect them."* (FGD A)

Midwives were said to be closer to the patients than physicians because they spend more time with them. Pregnant women were also reported to prefer to turn to midwives with their questions as some patients were said to be intimidated by physicians' high educational level.

> *"I think it is easier for patients to get in contact with us rather than with doctors, as we are midwives. Patients often feel reluctant when getting in touch with doctors as they feel inferior in terms of their level of knowledge."* (FGD C)

Counselling is an important part of antenatal care

Counselling pregnant women about healthy behaviour and the importance of physical examinations were reported as major components of midwives' duties. Physicians also counselled pregnant women, although physicians were said to be very busy, so the major part of counselling was performed by midwives, especially at higher level hospitals.

> *"Because they are so busy, one doctor has to examine more than one hundred patients* [per day]*, so how many minutes for one patient? Thus, counselling falls under the responsibility of experienced midwives."* (FGD A)

Because of the limited time allocated for physician consultations, for example when performing an ultrasound examination, the midwives believed that pregnant women were not always properly informed about the results of the examination. Pregnant women were said to commonly ask midwives about the results from the ultrasound examination and felt insecure when attending the hospital. As a consequence, the midwife had an important mission to inform women and to help them feel confident. Participants reported that it was important to adjust their counselling depending on the pregnant woman's knowledge level.

> *"Some patients are very knowledgeable, have high educational level, but some don't… We have to act depending on each patient…. Our goal is to make patients understand what we are counselling."* (FGD C)

Rewarding role but also vulnerable position

Mostly exposed to pressure but also experiencing joy

Participants all agreed that the most positive aspect of working as a midwife was when the mother and the baby were healthy after the delivery and when the mother was satisfied with provided care. Other joyful parts of the work were described as being able to fulfil their duties well, to assist in uncomplicated births and to be able to satisfy the patients' needs.

> *"The happiest thing in our work is when the baby is born healthy, when we can hear the baby's cry, when both the mother and the baby are safe."* (FGD D)

Although the participants enjoyed many parts of their work, it was also described that midwives' suffered a lot of pressure in their work such as high workloads because of crowded hospitals and fear of doing something wrong.

> *"We have to suffer a lot of pressure, the ward is so crowded and we are so busy… They* [patients] *never keep in mind the good things that we do for them, but one little bad thing will be remembered for their whole life."* (FGD B)

Pregnant women paying for healthcare at higher level hospitals were also thought to be putting more pressure on health professionals as they were seen as being less accepting about experiencing complications.

> *"They* [patients] *think that they pay for us, so they dońt want to suffer any problems."* (FGD A)

Feeling unfairly blamed for adverse events

Experiences of being unfairly blamed for complications that occurred during childbirth was expressed in all FGDs. After an adverse event had occurred, it was reported that the patient's family sometimes came to the hospital to scold the health professionals involved. Some participating midwives felt they were blamed for complications to a greater extent than physicians, and that they were sometimes also blamed by the physicians.

> *"When any complication happens, all of our team has to suffer. Patients and their families come here to shout at us, insult us…. But as health staff, we have to be more patient, we have to keep calm. We can't fight back if they attack us."* (FGD B)
>
> *"They* [patient's family] *don't care about the reasons* [for complications] …. *Even doctors blame us."* (FGD A)

Participants tried to explain the complications that had occurred to the patients and their families, however they sometimes felt it was difficult to make them understand that some complications are unavoidable. Besides feeling unfairly treated, participants also described the risk of being affected financially.

> *"They* [patient's family] *don't understand that we have tried our best to bring all good things to their family but what happened is unfortunate. And sometimes complications are unavoidable…. We have to deal with their opinions, their comments, and even litigation, or even their request for reimbursement."* (FGD D)

Some participants reported that they felt very stressed after their work shift as they could afterwards be contacted from their workplace and become exposed to criticism.

> *"I think my work has brought me lots of happiness, but not as much as worry. Our responsibility is so great. On duty, we have to stay awake for the whole night, which makes us really tired. But we keep worrying as we dońt know if there will be any subsequent call* [criticising us] *or not."* (FGD A)

Mass media reports about obstetric complications that had occurred at the obstetric departments were experienced in general as without any nuance. It was reported that journalists gave information that health professionals were acting irresponsibly which the participants disagreed with.

> *"I used to appreciate journalism a lot. But now I feel allergic to that job… I think journalists now often stay by the people's side* [unfairly]*."* (FGD D)
>
> *"There are not many adverse events within midwifery but it attracts so much attention."* (FGD A)

When pregnancy or delivery related complications occurred, some participants felt a lack of support by the government. Some stated that there should be legal documents regulating how to deal with adverse events and a law to protect health staff from being financially or occupationally affected.

Morally challenging tasks

Double standard for sex determination and pronounced preference for sons

A topic raised in most FGDs was the use of ultrasound for determination of the fetal sex. The participants stated that health professionals were prohibited to reveal fetal sex during ultrasound examinations, a rule considered to be mostly applied in public hospitals. However, the participants reported that it was common knowledge that fetal sex was actually revealed at consultations in private clinics, although the information was only provided verbally and in an indicative way, such as mentioning that "the fetus is like the mother or the father". Participants described pregnant women in general as being very curious about the fetal sex, and they believed that private clinics revealed that information in order to attract more clients.

> *"…. almost all pregnant women know the sex of their babies. It must be 80 to 90%."* (FGD D)

The preference for a son was described as a deep-rooted tradition in Vietnam. A pregnant woman's husband or husband's family could coerce a woman to have many children or to undergo sex selective abortions in order to have a son. Some people applied early sex determination techniques to get information about the fetal sex in order to undergo sex selective abortions. Although sex selection through abortion is prohibited in Vietnam, based on the gestational age when fetal sex could be determined through ultrasound, participants often assumed that the reason for abortion was in fact the female sex of the fetus.

> *"Sometimes the ultrasound examination is abused. Thanks to ultrasound examinations, they may know the sex of the baby and thus* [decide to] *have an abortion, which is really such a pity."* (FGD D)

The high birth rate of boys compared with girls was an issue well-known to the participants. Some expressed a fear for the future of Vietnamese society due to so many abortions being performed on female fetuses, thus creating a female deficit in the population.

> *"Now the sex ratio is really unbalanced, so in 2020 the ratio may be really, really unbalanced."* (FGD A)

Emotionally stressful to work with abortion services

Legal abortions were reported to be common in Vietnam, especially at early gestational age. One reason for the high number of legal abortions was reported to be insufficient knowledge about reproduction and contraceptive methods. Participants mentioned that sexual and reproductive health issues have not been included in education programs, thus leading to high rates of abortions, especially for adolescents.

> *"I feel very sorry for them* [young women] *as they are not equipped with knowledge. So they might get pregnant, and then have an abortion, which might result in many complications."* (FGD B)

Some participants described health professionals as being reluctant to work with abortion services. Young midwives and physicians had to gain experience by working in an abortion clinic, but it was reported that older health professionals chose not to work there. The ethical issues in managing abortions were said to be what made health professionals reluctant to work in abortion clinics.

> *"In fact, those people working in that department* [abortion clinic] *still have to work to earn their living, but they really don't feel satisfied, and they often go to the pagoda or do something to ease their conscience."* (FGD A)

Caesarean section on maternal request

Participants described pregnant women with sufficient financial resources choosing to have a caesarean section without medical indication at the "service area" at higher level hospitals. It was reported that caesarean sections were prevalent, and one contributing factor was the strong cultural belief in fortune telling. It was therefore common that pregnant women were inclined to select a physician, a date and a time for their caesarean section.

> *"Some patients use the caesarean section services as they have fortune telling to get the date and time of caesarean section. They want to have a caesarean at the exact time they have been given, as otherwise, they are afraid that their babies will be* [negatively] *impacted."* (FGD B)

The fear of being blamed, if complications occurred during a normal delivery, was also a driving force to perform non-medical caesarean sections. Some concluded that the higher number of caesarean sections performed were related to improved income and living conditions among people in Vietnam. Pregnant women were also described as being too worried to give birth vaginally, and their endurance during labour and birth was reported as lower than in the past.

> *"They are too worried and if there's any problem happening* [during birth], *we would be blamed for not giving them caesarean section."* (FGD B)

Discussion

This study explored Vietnamese midwives' experiences of working in Vietnamese maternity care. The overall theme, "Practising midwifery requires commitment", reflects how the participating midwives' dedication to their work and to women's reproductive health helped them to cope with the negative aspects of their work environment. The theme also represents the pressure midwives experience, of always needing to be alert and flexible to meet diverse patient needs. High workload, ethically demanding care roles and experiences of being in a vulnerable position when adverse events occurred were also starkly evident in the participating midwives' accounts. In the category, "Being the central link in the web of care", the midwives' role in maternity care is described as very important with close relationships with pregnant women. Collaboration with other health professions was mostly assessed as satisfactory, although hierarchal structures between physicians and midwives were clearly evident. Improved interprofessional collaboration between health workers may increase the quality of care and also increase motivation and decision-making abilities among midwives and other skilled birth attendants [32]. However, the interaction between midwives and obstetricians may be characterised as being competitive rather than collaborative due to historical tensions [33]. It can be assumed that the hierarchical structure between these two health professions is due not only to their professional roles but also to gender, as midwifery is a traditionally female profession, while most physicians historically have been males. In the global report "Midwives' Voices, Midwives' Realities", experiences of poor treatment of midwives were linked to gender inequality and discrimination against women [34]. Economic, socio-cultural and professional barriers, situated in gender inequality, are also reported to be important barriers to provision of quality midwifery care in low and middle income countries. In addition, gender inequality has also been described as the primary barrier to the advancement of the midwifery profession [35].

In the category, "Rewarding role but also vulnerable position", the participants described the positive aspects of midwifery, when pregnant women give birth without complications and when the patients were satisfied with the provided care, but also the frustration of the midwives being blamed for adverse events not possible to foresee or to prevent. Exhaustion among Vietnamese nurses has been shown to be caused not only by high workload but also by lack of fairness and rewards. Lack of effective appeals procedures for nurses who question the fairness of a decision, can add to exhaustion and stress [36]. In a Vietnamese study of health professionals' experiences of being involved in adverse medical events, a majority reported that the adverse event had impacted on their

mental and physical health, as well as their job satisfaction. Despite this, many health professionals experience little learning and change occurring in the workplace after reporting an incident [37]. Experiences of being blamed or punished after an adverse event have also been reported by health professionals [36]. Our study showed that midwives feared being blamed after an adverse event had occurred and it was especially hard to manage when they were subjected to blame by patients and family. Violence against health professionals at their workplace has been reported as high, especially in Asia and North America [38]. In China, most physicians [39] and nurses have encountered physical or verbal workplace violence from patients and their relatives [40]. The high prevalence of workplace violence towards health professionals in Asian countries may reflect the structure of the healthcare system including high workloads among health professionals, with long waiting times and less time for communication with patients, as well as the care context and culture [38]. Patients in Vietnam are found to have generally low levels of satisfaction with health care. Key issues include lack of transparency in information provision and explanation of procedures, concerns about the capabilities and attitudes of health professionals, poor facilities and equipment, and concerns about service outcomes [41]. An improved work environment and fewer patients per nurse are associated with increased patient satisfaction and quality of care [42]. To decrease the workload for health professionals at higher level hospitals and to be able to provide higher quality healthcare, the distribution of patients across the health system in Vietnam needs to change. Although the number of health professionals has increased during recent years in Vietnam [24], the health sector still faces a shortage of human resources.

In the category, "Morally challenging tasks", midwives reported that legal abortions could be ethically demanding although an evident part of reproductive care. Revealing and reporting fetal sex to expectant parents and sex selective abortions were experienced as occurring even though these are prohibited. These concerns have previously been reported among obstetricians in Vietnam as well [43]. According to the "National guidelines for reproductive healthcare services" in Vietnam, health professionals should ask questions during counselling for a second trimester abortion, to find out if the abortion is due to sex selection [44]. Voices have been raised that this could threaten women's abortion rights leading to a negative impact on womeńs access to safe abortions [45]. Health professionals in Nepal have described the difficulty of determining which patients are seeking abortion because of sex selection, as they are aware of the pressure some women feel to bear a son and the risk that they therefore may seek unsafe abortion services instead [46]. It has also been noted that nurses providing counselling at abortion clinics in Vietnam generally do not follow The World Health Organization (WHO) guidelines on abortion counselling and are not always adequately trained. Instead, the counselling is often based on personal perceptions and by weak regulatory frameworks and is affected by overloaded work schedules. In addition, nurses providing abortion counselling have similar backgrounds and often share similar beliefs about sex selection as their patients and it has been noted that counselling has done little to date to reduce the number of sex selective abortions [47].

The imbalanced sex ratio is seen especially among households with higher socioeconomic status. Low fertility rates and access to ultrasound examinations are reported as explanatory factors for the use of prenatal sex selection among well-off couples. The prevalence of prenatal sex selection in the Red River Delta region, including the Hanoi area where this data collection was performed, is among the highest in Vietnam [48]. Stronger implementation of regulations and laws, and sizeable penalties for violating the ban on prenatal sex determination through ultrasound, has been suggested to demonstrate the Vietnamese Government's intention to bring about a return to a normal SRB level by 2025 [49]. However, deep seated beliefs are rarely changed by legislation unless accompanied by other interventions. As traditional family values and a culture of male domination are important keys to gender bias, additional initiatives are needed to move towards gender equity [47,48]. The WHO has issued several recommendations to prevent gender biased sex selection. These include involving stakeholders at all levels to put in place legal and policy measures for women and girls, in combination with mass-media strategies and other social measures to encourage societal change of this deep-rooted practice [27].

Strengths and limitations

A strength of this study was the purposive sampling, including participants from urban, semi-urban and rural areas of Hanoi and from different levels of healthcare. The constellation of participating midwives with different ages and length of work experience in each FGD contributes to the credibility of the study. Transferability was facilitated through a rich description of the data collection and the data analysis as well as quotations from the participants. The FGDs were digitally recorded and notes on informal communication were taken, to go back to in case of uncertainty of findings, increasing dependability. In addition, the same researcher moderated all FGDs and used an interview guide to ensure that the same topics were discussed. A limitation of the study might have been that the moderator was a medical doctor by profession while the participants were midwives, something which may have affected the midwives' inclination to speak freely in relation to the hierarchical Vietnamese healthcare system. However, the midwives' narratives also included criticism against doctors which indicates that the content of the FGDs have not been greatly affected by the different health professions of the moderator and the participants. The research team consisted of researchers from different countries and different professions, which increased the confirmability of the study findings as it provided a rich opportunity for different viewpoints, perspectives and preferences to be contested and discussed during the analysis and interpretation of the findings [50]. The FGDs were moderated in Vietnamese by a native speaking member of the research team, which is as an additional strength of this study. Inadequate translation may affect the trustworthiness of studies [51]. Therefore, the English translated materials were control-read by the moderator and compared with the Vietnamese transcriptions several times, something which only resulted in minor changes to the text. A potential limitation of this study was that a young male interpreter participated in the FGDs to assist the non-Vietnamese speaking observers, while the participants and the research group were all females. Due to traditional hierarchical differences between genders in Vietnam, this could have influenced the content of the discussions. Given that the discussions in all focus groups were lively and the participants were eager to express their views, we think that this is unlikely to have affected the content of the discussion to any great extent. Although the data collection was performed in 2013, the challenges in maternity care are still issues in contemporary Vietnam [17,52].

Conclusions

Working as a midwife in the Vietnamese healthcare system was perceived as challenging and multifaceted. Although the participating midwives viewed midwifery in essentially positive ways, they felt significant pressure because of high workload, ethically demanding duties and vulnerability to criticism when adverse obstetric events occurred. Additional services, such as non-medical ultrasounds and caesarean sections, were sometimes performed to satisfy patients. Interventions to inform Vietnamese citizens about reproductive issues may increase the understanding of evidence-based maternity care, in order to reduce the number of unnecessary, and sometimes risky, interventions during pregnancy and childbirth. Information to the public on complications that can occur during pregnancy and childbirth and targeted antenatal education may also increase the understanding of adverse obstetric events. For future studies, other instruments and study designs can be used to explore Vietnamese midwives' perspectives of working within

maternity care, including work strain and burnout levels.

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Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Data statement

The datasets generated and analysed during the current study are not publicly available due to privacy consideration of the participants but are available from the corresponding author on reasonable request.

References

[1] UNFPA, International Confederation of Midwives, WHO. The State of the World's Midwifery. A universal pathway. A woman's right to health. New York: United Nations Population Fund; 2014. https://www.unfpa.org/sites/default/files/pub-pdf/EN_SoWMy2014_complete.pdf [accessed 30 June 2021].
[2] Rayment J. Emotional labour: how midwives manage emotion at work. Pract Midwife. 2015;18(3):9-11. PMID: 26349324.
[3] Pezaro S, Clyne W, Turner A, Fulton EA, Gerada C. 'Midwives Overboard!' Inside their hearts are breaking, their makeup may be flaking but their smile still stays on. Women Birth 2016;29(3):e59–66. https://doi.org/10.1016/j.wombi.2015.10.006.
[4] Cramer E, Hunter B. Relationships between working conditions and emotional wellbeing in midwives. Women Birth 2019;32(6):521–32. https://doi.org/10.1016/j.wombi.2018.11.010.
[5] Fleming V, Frith L, Luyben A, Ramsayer B. Conscientious objection to participation in abortion by midwives and nurses: a systematic review of reasons. BMC Med Ethics 2018;19(1):31. https://doi.org/10.1186/s12910-018-0268-3.
[6] Li Y-L, Li R-Q, Qiu D, Xiao S-Y. Prevalence of workplace physical violence against health care professionals by patients and visitors: a systematic review and meta-analysis. Int J Environ Res Public Health 2020;17(1):299. https://doi.org/10.3390/ijerph17010299.
[7] Tung LT, Anh TT, Chinh NTM, Long NH. Public reactions in online newspapers to workplace violence against nurses. SAGE Open Nurs 2021. https://doi.org/10.1177/23779608211003819.
[8] Gascon S, Leiter MP, Andrés E, Santed MA, Pereira JP, Cunha MJ, et al. The role of aggressions suffered by healthcare workers as predictors of burnout. J Clin Nurs 2013;22(21–22):3120–9. https://doi.org/10.1111/j.1365-2702.2012.04255.x.
[9] Suleiman-Martos N, Albendín-García L, Gómez-Urquiza JL, Vargas-Román K, Ramirez-Baena L, Ortega-Campos E, et al. Prevalence and predictors of burnout in midwives: a systematic review and meta-analysis. Int J Environ Res Public Health 2020;17(2):641. https://doi.org/10.3390/ijerph17020641.
[10] Jarosova D, Gurkova E, Palese A, Godeas G, Ziakova K, Song MS, et al. Job satisfaction and leaving intentions of midwives: analysis of a multinational cross-sectional survey. J Nurs Manag 2016;24(1):70–9. https://doi.org/10.1111/jonm.12273.
[11] Sidhu R, Su B, Shapiro KR, Stoll K. Prevalence of and factors associated with burnout in midwifery: a scoping review. Eur J Midwifery 2020;4:4. https://doi.org/10.18332/ejm/115983.
[12] Shen J, Cox A, McBride A. Factors influencing turnover and retention of midwives and consultants: a literature review. Health Serv Manage Res 2004;17(4):249–62. https://doi.org/10.1258/0951484042317769.
[13] Bloxsome D, Ireson D, Doleman G, Bayes S. Factors associated with midwives' job satisfaction and intention to stay in the profession: an integrative review. J Clin Nurs 2019;28(3–4):386–99. https://doi.org/10.1111/jocn.14651.
[14] World Health Organization Regional Office for the Western Pacific. Human resources for health country profiles: Vietnam. Geneva, Switzerland; 2016. http://iris.wpro.who.int/handle/10665.1/13476 [accessed 16 December 2021].
[15] Central population and housing census steering committee. Results - The Viet Nam population and housing census of 00:00 hours on 1 April 2019. March, 2020. https://vietnam.unfpa.org/sites/default/files/pub-pdf/Results - 2019 Population and Housing Census_full.pdf [accessed 16 December 2021].
[16] Ministry of Health Viet Nam. Health Statistics Yearbook 2018. Ha Noi, Viet Nam; 2020. https://moh.gov.vn/documents/176127/0/NGTK+2018+final_2018.pdf/29980c9e-d21d-41dc-889a-fb0e005c2ce9 [accessed 20 December 2021].
[17] Holmlund S, Lan PT, Edvardsson K, Phuc HD, Ntaganira J, Small R, et al. Health professionals' experiences and views on obstetric ultrasound in Vietnam: a regional, cross-sectional study. BMJ Open 2019;9(9). https://doi.org/10.1136/bmjopen-2019-031761.
[18] Nguyen THT, McDonald F, Witter S, Wilson A. "Three Nooses on Our Head": the influence of district health reforms on maternal health service delivery in Vietnam. Int J Health Policy Manag 2018;7(7):593–602. https://doi.org/10.15171/ijhpm.2017.134.
[19] Nguyen MP, Wilson A. How could private healthcare better contribute to healthcare coverage in Vietnam? Int J Health Policy Manag 2017;6(6):305–8. https://doi.org/10.15171/ijhpm.2017.05.
[20] National Assembly Viet Nam. Order No. 23/2008/L-CTN, Law on health insurance; 2008. https://www.ilo.org/dyn/natlex/natlex4.detail?p_isn=82231&p_lang=en [accessed 16 December 2021].
[21] Ngo AD, Hill PS. The use of reproductive healthcare at commune health stations in a changing health system in Vietnam. BMC Health Serv Res 2011;11(1):237. https://doi.org/10.1186/1472-6963-11-237.
[22] UNFPA and Ministry of Health Viet Nam. Viet Nam Midwifery Report 2016. Hanoi, Viet Nam; 2017. https://vietnam.unfpa.org/sites/default/files/pub-pdf/Web_Midwifery_Eng.pdf [accessed 30 June 2021].
[23] Bearak J, Popinchalk A, Ganatra B, Moller A-B, Tunçalp Ö, Beavin C, et al. Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990–2019. The Lancet Global Health 2020;8(9):e1152–61. https://doi.org/10.1016/S2214-109X(20)30315-6.
[24] Ministry of Health Viet Nam. Health Statistics Yearbook 2015. Ha Noi, Viet Nam; 2017. https://moh.gov.vn/documents/176127/0/NGTK2015_final_2015.pdf/d52e16a2-9a33-42b0-82cf-7539c49ac3b7.
[25] Decree No. 104/2003/Nd-Cp. Detailing and guiding the implementation of a number of articles of the population ordinance; 2003. https://vanbanphapluat.co/decree-no-104-2003-nd-cp-of-september-16-2003-detailing-and-guiding-the-implementation-of-a-number-of-articles-of-the-population-ordinance.
[26] General Statistics Office, Viet Nam and UNFPA. The Population and Housing Census 2019. Sex imbalances at birth: Trends, Variations and Determinants. Ha Noi, Viet Nam; 2020. https://vietnam.unfpa.org/sites/default/files/pub-pdf/ty_so_gioi_tinh_khi_sinh_eng.pdf [accessed 16 December 2021].
[27] World Health Organization. Preventing gender-biased sex selection. An interagency statement OHCHR, UNFPA, UNICEF, UN Women and WHO. Geneva, Switzerland: WHO; 2011. https://apps.who.int/iris/bitstream/handle/10665/44577/9789241501460_eng.pdf;jsessionid=925FA8D6DB6AF53D0C76334C57DD0A67?sequence=1 [accessed 16 December 2021].
[28] de Loenzien M, Schantz C, Luu BN, Dumont A. Magnitude and correlates of caesarean section in urban and rural areas: A multivariate study in Vietnam. PLoS ONE 2019;14(7):e0213129. https://doi.org/10.1371/journal.pone.0213129.
[29] Lincoln, YS, Guba EG. Naturalistic inquiry. Beverly Hills: Sage Publications; 1985.
[30] Holmlund S, Lan PT, Edvardsson K, Ntaganira J, Graner S, Small R, Mogren I. Sub-optimal use of ultrasound examinations may result in underperformance of Vietnamese maternity care - A qualitative study of midwives' experiences and views. Sex Reprod Healthc 2020;24. https://doi.org/10.1016/j.srhc.2020.100508.
[31] Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. Nurse Educ Today 2004;24(2):105–12. https://doi.org/10.1016/j.nedt.2003.10.001.
[32] Munabi-Babigumira S, Glenton C, Lewin S, Fretheim A, Nabudere H. Factors that influence the provision of intrapartum and postnatal care by skilled birth attendants in low- and middle-income countries: a qualitative evidence synthesis. Cochrane Database Syst Rev 2017;11(11):CD011558. https://doi.org/10.1002/14651858.CD011558.pub2.
[33] van der Lee N, Driessen EW, Houwaart ES, Caccia NC, Scheele F. An examination of the historical context of interprofessional collaboration in Dutch obstetrical care. J Interprof Care 2014;28(2):123–7. https://doi.org/10.3109/13561820.2013.869196.
[34] World Health Organization. Midwives voices, midwives realities. Findings from a global consultation on providing quality midwifery care. Switzerland; 2016. https://apps.who.int/iris/handle/10665/250376 [accessed 20 November 2021].
[35] Filby A, McConville F, Portela A. What prevents quality midwifery care? A systematic mapping of barriers in low and middle income countries from the provider perspective. PLoS ONE 2016;11(5). https://doi.org/10.1371/journal.pone.0153391.
[36] Nguyen HTT, Kitaoka K, Sukigara M, Thai AL. Burnout study of clinical nurses in Vietnam: development of job burnout model based on Leiter and Maslach's theory. Asian Nurs Res 2018;12(1):42–9. https://doi.org/10.1016/j.anr.2018.01.003.
[37] Harrison R, Sharma A, Walton M, Esguerra E, Onobrakpor S, Nghia BT, et al. Responding to adverse patient safety events in Viet Nam. BMC Health Serv Res 2019;19(1):677. https://doi.org/10.1186/s12913-019-4518-y.
[38] Liu J, Gan Y, Jiang H, Li L, Dwyer R, Lu K, et al. Prevalence of workplace violence against healthcare workers: a systematic review and meta-analysis. Occup Environ Med 2019;76(12):927–37. https://doi.org/10.1136/oemed-2019-105849.
[39] Sun T, Gao L, Li F, Shi Y, Xie F, Wang J, et al. Workplace violence, psychological stress, sleep quality and subjective health in Chinese doctors: a large cross-sectional study. BMJ Open 2017;7(12). https://doi.org/10.1136/bmjopen-2017-017182.

[40] Zhang L, Wang A, Xie X, Zhou Y, Li J, Yang L, et al. Workplace violence against nurses: a cross-sectional study. Int J Nurs Stud 2017;72:8–14. https://doi.org/10.1016/j.ijnurstu.2017.04.002.
[41] Thach Phuong N, Vu Hoang P, Mac Dang T, Nguyen Thi Huyen T, Ngo Thi T. Improving hospital's quality of service in Vietnam: the patient satisfaction evaluation in multiple health facilities. Hosp Top 2021;27:1–11. https://doi.org/10.1080/00185868.2021.1969871.
[42] Aiken LH, Sermeus W, Van den Heede K, Sloane DM, Busse R, McKee M, et al. Patient safety, satisfaction, and quality of hospital care: cross sectional surveys of nurses and patients in 12 countries in Europe and the United States. BMJ 2012;344. https://doi.org/10.1136/bmj.e1717.
[43] Edvardsson K, Graner S, Thi LP, Ahman A, Small R, Lalos A, et al. 'Women think pregnancy management means obstetric ultrasound': Vietnamese obstetricians' views on the use of ultrasound during pregnancy. Glob Health Action 2015;8(1):28405. https://doi.org/10.3402/gha.v8.28405.
[44] Ministry of Health Viet Nam. National clinical guidelines on reproductive health care services. Ha Noi; 2009.
[45] Sen G. Gender Biased Sex Selection: Key Issues for Action; 2009. https://www.dawnnet.org/uploads/documents/Sex Selection GS draft 08062009_2011-Mar-8.pdf [accessed 16 December 2021].
[46] Lamichhane P, Harken T, Puri M, Darney PD, Blum M, Harper CC, et al. Sex-selective abortion in Nepal: a qualitative study of health workers' perspectives. Women's Health Issues 2011;21(3, Suppl):S37–41. https://doi.org/10.1016/j.whi.2011.02.001.
[47] Hang TM. Global Debates, Local dilemmas. Sex-selective abortion in contemporary Viet Nam. ANU Press; 2018. http://doi.org/10.22459/GDLD.2018 [accessed 19 November 2021].
[48] UNFPA. Sex imbalance at birth in Viet Nam 2014. Recent trends, factors and variations. Ha Noi, Viet Nam: Labour-social publishing house; 2016. https://vietnam.unfpa.org/en/publications/sex-imbalances-birth-viet-nam-2014-recent-trends-factors-and-variations [accessed 25 June 2021].
[49] UNFPA. The Imbalanced Sex Ratio at Birth in Viet Nam: New insights and policy recommendations. 2019. https://vietnam.unfpa.org/en/publications/imbalanced-sex-ratio-birth-viet-nam-new-insights-and-policy-recommendations [accessed 25 June 2021].
[50] Korstjens I, Moser A. Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. Eur J Gen Pract 2018;24(1):120–4. https://doi.org/10.1080/13814788.2017.1375092.
[51] Squires A. Methodological challenges in cross-language qualitative research: a research review. Int J Nurs Stud 2009;46(2):277–87. https://doi.org/10.1016/j.ijnurstu.2008.08.006.
[52] Takegata M, Smith C, Nguyen HAT, Thi HH, Thi Minh TN, Day LT, et al. Reasons for increased caesarean section rate in Vietnam: a qualitative study among vietnamese mothers and health care professionals. Healthcare 2020;8(1):41. https://doi.org/10.3390/healthcare8010041.