AN ANALYSIS OF BIRTHS OUTSIDE HEALTH FACILITIES IN MASERU HEALTH SERVICE AREA LESOTHO

BY

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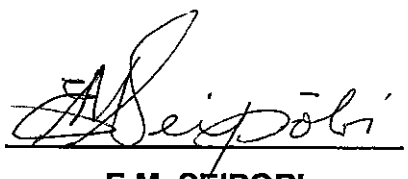
I declare that the dissertation hereby submitted by me for the Masters Social Science (Nursing) degree at the University of Free State is my own independent work and has not previously been submitted by me at another university faculty. I furthermore cede copyrights of the dissertation in favor of the University of the Free State.



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DEDICATION

I dedicate this dissertation to my children Nthuwa, Maneo Seipobi, Baile Maitumeleng Seakhoa, Thebe, Matiisetso Seipobi for their overwhelming support and encouragement throughout my study period.

My grandchildren Mpho and Tshepo, Seakhoa, Tshepang, Neo, Tiisetso and Nthabeleng Seipobi take courage from this humble work for your learning over the years and it will pay off at the end.

ACRONYMS

ANC	Ante Natal Care
AIDS	Acquired Immune Deficiency Syndrome
CHAL	Christian Health Association of Lesotho
HAS	Health Service Area
HIV	Human Immune-deficiency Virus
ICM	International Confederation of Midwives
MDG	Millennium Development Goals
MOH/SW	Ministry of Health and Social Welfare
MRC	Medical Research Council
TBA	Traditional Birth Attendant
QE II	Queen Elizabeth II Hospital
VVF	Vesico Vaginal Fistula
WHO	World Health Organization

TABLE OF CONTENTS

CHAPTER 1

INTRODUCTION AND PROBLEM STATEMENT

CHAPTER 2

LITERATURE REVIEW

CHAPTER 3

RESEARCH METHODOLOGY

CHAPTER 4

EXPLANATION OF THE RESULTS OF THE STUDY

CHAPTER 5

FINDINGS, CONCLUSIONS AND RECOMMENDATIONS OF THE STUDY

ADDENDUMS

LIST OF FIGURES

Page

LIST OF TABLES

Page

Page

CHAPTER 1

INTRODUCTION AND PROBLEM STATEMENT

1.1 INTRODUCTION

Although 90% of all pregnant women use professional health care facilities for antenatal care (four or more visits) only 52 percent of births in Lesotho are assisted by a nurse, midwife or doctor in a health facility (Ministry of Health and Social Welfare and Bureau of Statistics, 2004:124). According to Ateka (2000:6) births outside a health facility are common in Maseru Health Service Area but the actual statistics regarding the exact numbers are lacking. Health providers in various health sectors in Maseru Health Service Area have observed that when a birth takes place outside a health facility the risk for complications like postpartum haemorrhage, sepsis and vesico vaginal fistula (VVF) increase. These health providers become aware of these problems when women come for help to the health facility after the birth of their babies born outside a health facility (Ministry of Health and Social Welfare, 2003:17).

There are various reasons why women give birth outside health facilities. It can either be by free choice or forced choice, for example, where the mother chooses to have her baby at home due to cultural reasons or is forced to give birth supported by an unskilled person. Births outside a health facility (on her way to a health facility) can be a very special experience or a very frightening experience (Mohapi, 1994).

1.2 BACKGROUND

1.2.1 Geography

Lesotho is surrounded by the Republic of South Africa. It occupies a land area of approximately thirty thousand square kilometers and has an estimated population of 2.1 million (Bureau of Statistics, 1996). The country lies between latitude 28◦ and 31◦ south and between longitudes 27◦ and 30◦ east (Ministry of Health and Social Welfare, 1993 MOHSW).

The highland and mountains in Lesotho cover three quarters of the country rising to nearly 3500 meters above sea level in the Drakensberg range. The remaining one quarter forms the lowlands. The topography of Lesotho makes it a difficult terrain in terms of accessibility and leaves very limited land for cultivation. The mountains in the country contribute to a temperate climate, which is variable. In the lowlands summers are warm (mean maximum temperature is 30◦C in January) with occasional rain and the winters are dry and very cold (mean minimum temperature is -1◦C). The climate of the mountain region is harsher with cool summers and cold winters often accompanied by snow (mean minimum temperature is 7◦C) and hail storms. This further limits accessibility to services as roads are normally flooded. This can result in a life threatening situation and sometimes in fatality as mothers who are at risk, and need services during that period of floods will not be able to visit a clinic or hospital. This may result in complications when women give birth outside a health facility (Minister of Health and Social Welfare, 1996: 1 MOHSW).

1.2.2 Social and economic factors

Lesotho's economic structure comprises of agriculture and labour ~~export~~, but Lesotho still depends heavily on external donations. Over 70% of the population

depends on subsistence farming which accounts for 20% of gross domestic product (GDP). Unemployment is estimated at 35% to 45%. If household members are unemployed, the payment of maternal services will not be possible (Bureau of Statistics, 1996:11). Increased urban migration has contributed to increasing urbanization that pressurizes urban social services (Bureau of Statistics, 1996:12). According to the Lesotho High Land Development Authority (2003:1) Lesotho's transport and communication has improved since 1966. The construction of roads and provision of communication by land and mobile phones has taken place. However, other rural and peri-urban areas are still without roads and transport.

1.2.3 Structure of health services

A dual health care system exists in Lesotho, a professional system based on the bio-medical model provided by the Ministry of Health and Social Welfare and also by the Christian Health Association of Lesotho. Health services are not completely free, women attending antenatal care pay for initial registration but subsequent visits are free. Other payments will be made after giving birth and such fees are from R20.00 to R100.00 in government health facilities. The private sector fees are M150.00 and more. The Ministry of Health and Social Welfare (MOHSW) is primarily responsible for the development of policies, strategies and programmes for health care in Lesotho. The country is divided into nineteen Health Service Areas (HSA). HSA hospitals are a key element of the health infrastructure. The second system is the traditional health care system based on the holistic model which is practiced by the traditional health care providers. (Maieaue M.V. 1998)

3. STATEMENT OF THE PROBLEM

According to the Ministry of Health and Social Welfare and Bureau of Statistics (2004:113), 90% of all pregnant women in Lesotho attend antenatal care at a health facility provided by a skilled provider. However only 52 percent of births in Lesotho are assisted by a skilled provider (nurse, midwife, and doctor) in a health facility (Ministry of Health and Social Welfare and Bureau of Statistics, 2004:130). According to Mohai and Thahane (2000) who reviewed records that showed that 9231 pregnant women received antenatal care of which 2140 (23%) were teenagers. Al-Nehadh (2002:4) states that teenage pregnancy increases the risk for both mother and baby, to develop complications. This risk can increase if they give birth outside a health facility unattended or attended by an unskilled helper. Some of the risks of birth outside a health facility are prolonged labour, perineal tear and fistula. (Ateka 2000)

Births outside health facilities are common in Maseru Health Service Area. Actual statistics regarding numbers of those women who give birth outside a health facility are lacking (Ateka, 2000). However Lesotho has a high maternal death rate of 762/per 100,000 live births and a neonatal death rate of 91/1,000 live births. These death rates are only based on reported deaths by health facilities, health reports from outside the health facility are lacking, therefore it means that the death rates could be much higher.

To illustrate antenatal attendance and births at health facilities in Maseru Health Service Area during 2005 see table 1.1.

Table 1.1: The number of antenatal care visits and births at health facilities in Maseru HSA during 2005.

Health facilities	Total number of antenatal care attendance	Total number of births at health facility
Bethany	293	40
Good Shepherd	573	11
Holy Family	481	51
Qoaling Filter Clinic	2 448	261
Maseru Private Hospital	224	84
Matukeng Clinic	347	16
Makoanyane Hospital	444	148
Khubetsoana Clinic	1 128	904
Queen Elizabeth II MCH/FP	10 325	6 058
Total	**16 263**	**7 573**

Source: MOH and SW Health Facility monthly records, 2005

From table 1.1 it is evident that although the majority of women attending antenatal care do not come back to give birth in the health facility, the question that comes to mind is "where do these mothers go to give birth?" Do they go to other health service areas or do they give birth at home?

It is against this background as outlined above that this research proposes to describe births outside health facility as a phenomenon.

1.4 AIM OF THE STUDY

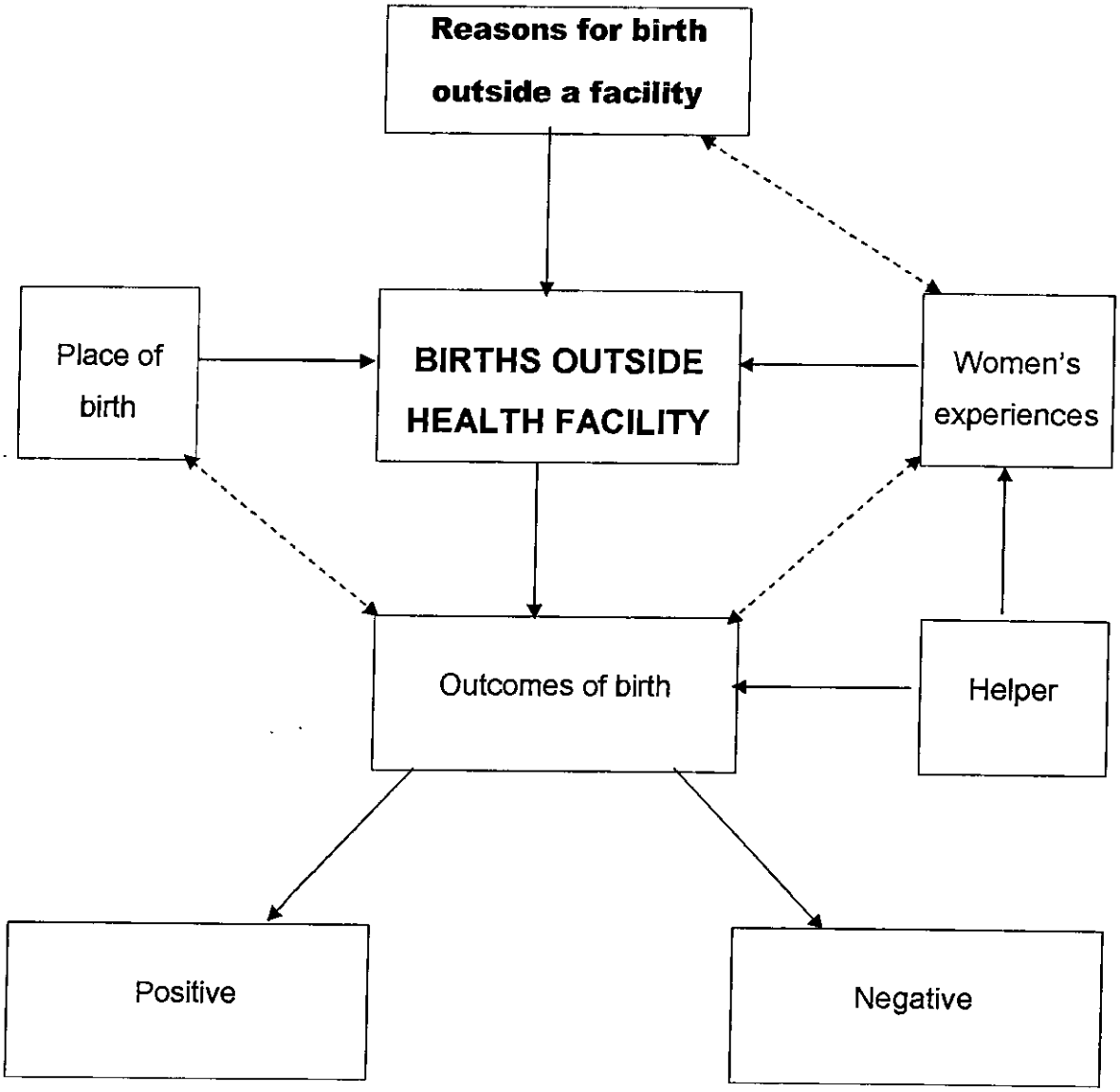
Based on the abovementioned problems the aim of the study is to describe births outside health facilities as a phenomenon. In Maseru Health Service Area – Lesotho.

1.4.1 Objectives

In accordance with the aim of the study the objectives are to:

- Identify reasons why women give birth outside health facilities.
- Identify where women give birth.
- Identify who the helper/attendant was during the birth.
- Explore the mother's experiences regarding the birth.
- Identify the outcome of the birth process.
- Describe the adherence to cultural health ritual and practice after the birth of the baby.

1.5 CONCEPTUAL FRAMEWORK



1.5.1 Relationship of concepts

In spite of antenatal care some mothers give birth outside health facilities. The outcome of these births can be positive or negative for mother and baby.

Some of the reasons why women give birth outside a health facility could be based on previous experiences at the health facilities, experiences such as being neglected while in pain, ask to walk around without any explanation. These are experiences women never forget. On the other hand women's experiences outside health facilities can be positive when the birth is planned. A planned birth outside a health facility can be in a clean prepared environment attended by a skilled helper. In a negative situation the environment will be uncomfortable with a stranger as an attendant or attended by an unskilled helper during the birth process. The outcome of such a situation ends in a birth with an unpleasant experience of neonatal and maternal morbidity and even a death. When birth outcomes are positive, the helper/attendant (family member, friend, neighbour) will be used again in birth. This positive experience can even be a reason for giving birth outside a health facility the next time. However, when the outcomes are negative the helper is likely not to be used again and the woman may consider using the health facility for the next birth.

The place of birth can be positive when in a controlled environment, where the equipment is sterile or clean versus an unclean place where the helper/attendant must use what is available (not necessarily clean). The place of birth can also influence the outcome of birth. The outcomes of a birth are influenced by the helper/attendant who can be careful, supportive and having the skills to attend a birth. An unskilled helper is likely to experience difficulty during the birth process when there is failure to make appropriate judgement that things are not moving in the right direction and there is need for professional help. An example of such a situation would be a women experiencing prolonged labour or is complaining of tiredness with a lot of sweating and is overlooked or unattended by the unskilled attendant. This situation requires urgent professional attention.

Adherence to cultural rituals and practices could be one of the reasons why women give birth outside health facility. In the health facility cultural values such as burial of placentae at home by selected person are not observed, instead

incineration of all placenta is practiced. An identified person in the family could be a helper/attendant who attends to birthing according to cultural practices in the family. In this way the family is assured that cultural rituals and practices are adhered.

There is interrelationship of the concepts of the conceptual framework e.g. women's experience and helper as well as outcomes of birth. The helper/attendant may be a family member who will assure that there is adherence to cultural practice and could be a reason for a birth outside a health facility. Some of the reasons for births outside health facilities are due to negative experiences that women had in the health facility (e.g. giving birth unattended in the labour ward) or the woman wanted to adhere to cultural practices and or that the helper/attendant is satisfied with the care of the woman during the birth process.

1.6 CONCEPT CLARIFICATION

Birth outside health facility: The birth of a baby in the home (Bennett & Brown, 2000:38). In this study home birth refers to a birth outside the health facility, for example, home, road or in public transport.

Traditional birth attendant (TBA): Is a respected village woman aged 40 years and above able to assist women during birth at home. This woman has children of her own and has experienced a home birth herself. She acquired birthing abilities by assisting other elderly women by handing required supplies and massaging the mother during a home birth. This

traditional helper is not trained in medical care (Letsie, 1998). For the purpose of this study, traditional helper refers to family member, friend or neighbour not trained at all.

Unskilled helper: Traditional birth attendant, Taxi driver, friend, neighbour, etc. are regarded as unskilled helpers during the birth process (World Health Organization, 1998:24).

Skilled helper: This is a professional cadre of biomedically trained personnel which includes nurses/midwives and doctors (Ministry of Health and Social Welfare, 1997:98).

1.7 SUMMARY OF RESEARCH METHODOLOGY

A non-experimental design with a descriptive and exploratory nature and the survey as method will be used because there is limited research on births outside the health facility in Lesotho. According to Burns and Grove (2001:748) and Brink (1996:103) descriptive studies are conducted when little is known about the phenomenon.

Maseru Health Service Area is the area of research and eight of its health clinics will be purposely selected because they provide comprehensive services, e.g. antenatal care, intranatal care, postnatal care and family planning. All mothers who give birth outside health facility in Maseru Health Service Area that attended health care and give consent to participate in the study will be included.

A structured interview as a research technique will be conducted with mothers who given birth outside a health facility. This interview will be conducted with the help of an interview schedule that consists of closed-ended as well as open-ended questions.

A pilot study will be done to ensure the reliability and validity of the instrument.

Data will be collected in 8 health centres/clinics over a period of 6 weeks. The closed-ended questions of the schedule will be analysed by the Biostatistics Department of the University of the Free State using the SAS computer programme. Descriptive statistics namely frequencies and percentiles for categorical data and percentages for continuous data will be used to reduce, organize and to give meaning to the data. Open ended information will be analysed according to Tesch's model (Creswell, 1994:100 – 155).

The following ethical aspects will be addressed:

- The right of the respondent to withdraw from the study will be respected.
- Permission from the Ethical Committee of the University of the Free State will be obtained.
- Permission from the Ministry of Health and Social Welfare as well as Private Health Association of Lesotho will be obtained before entering the field.
- Confidentiality of data will be adhered to.

1.8 OUTLINE OF THE STUDY

Chapter 1: Introduction and problem statement

Chapter 2: Literature review
Chapter 3: Methodology
Chapter 4: Findings of the study
Chapter 5: Discussions, conclusion and recommendations
Chapter 6: Summary/opsomming

1.9 SUMMARY

In this chapter the problem has been stated as well as the aim and objectives. The summary of the research methodology has been outlined and the literature review will be discussed in Chapter 2.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Health care has been commissioned by all cultures since the beginning of time and, as such, takes place between two human beings – the health care user-in-need, namely the birthing mother and the care provider namely the skilled helper or the unskilled helper. To render quality maternity care that satisfies the birthing mother by fulfilling her and her baby's needs, both the skilled and the unskilled helper must be knowledgeable of the mother as a human being. In the light of the above, this chapter will explore the contours of the mother as a human being as well an overview of birth practices past and present, the care to be rendered to the mother as a holistic human being and strategies to improve the birth outcome for the mother.

2.2 THE MOTHER AS A HOLISTIC BEING

The birthing mother is a human being created by God with a unique dignity and celestial destination. As a human being, the mother has a unique structural personality that consists of a systematic dimension (the bodily, psychological and spiritual systems) and a functional dimension (cognitive, will and affective/emotive functions) which indicate a dynamical structural-function multi-unity. According to Oberholzer (1970) as well as Meyer, Moore and Viljoen (1997:558), in becoming a human being, the birthing mother lives in relationship with herself, other human beings, a Supreme Being, the world and on the strength of the choices she pursues, the mother becomes the person/human being she wants to be and can be.

The mother in relation to herself

- From birth to death, the mother lives from out her Self and wants to be somebody with her own identity. The essence of the mother's being is constantly in a process of development because of her interaction with other persons and the world she lives in. The choices and decisions the mother makes indicate how her "I" is formed as it is the driving force of all actions that are portrayed. This implies that the mother as a person becomes her personality. The personality of the mother reveals the type of person she has become and as such, comprises all her capabilities, qualities and possibilities as an individual (Nel, Sonnekus and Gerber, 1965:133-136). The mother strives to self-fulfillment and her personality develops according to a specific pattern of unfolding – her inherent ability grows gradually while her acquired capabilities are learned and undergo changes during her life time. Within this unfolding elapse the mother goes through different developing phases that offer particular challenges and possibilities as the mother is inseparably involved with her own development (Meyer *et al*, 1997:554).

- The birthing mother embraces a diversity and complexity of distinguishable (not separate) dimensions, namely, the physical, the psychological, the social and the spiritual. The physical dimension embraces the concrete and mortal body of the mother and she experiences corporeality. The mortal body is the anatomical-physiological structure that protects and enables the foetus to develop from gamete to a human being, the infant. The mother also experience her body as an instrument of life when giving birth and when touching, smiling, talking, breast-feeding her baby, she opens herself up to meet her baby as a human being (van Peursen, 1970:110).

- The psyche of the mother embraces her will, decision-making, actions, feelings/emotions, aspirations and intellect. Since the mother always participates through her feelings in any situation, her emotions give meaning to her experience of the birthing process which in turn influences her behavior to her baby, her family and to her supporters (skilled and unskilled helpers (Nel *et al*, 1965:8; van Peursen, 1970:110; and Meyer *et al*, 1997:562). Kitzinger (2000:69) states that when in an unfamiliar environment (such as a healthy facility) with unfamiliar people (health personnel that comes and goes), the mother may become afraid as the mother needs to feel supported and secure during childbirth and not be left alone. At home, according to Mohai & Thahane (2000), the mother is supported by friends and family and is not left alone. These familiar and trusted persons are around to encourage her to be in control of the birthing process; to rub her back and to give massages and attend to all her needs.

- As a human being the mother is body-psyche-spirit as she has a spiritual dimension, namely, a soul. Therefore, the birthing mother always lives in relation to a Supreme Being and has a conscience with a transcendental nature. Thus the mother can pray together with her family members and birth supporters while giving birth to her baby. And because the mother has a conscience she is enabled to make choices according to her own values and norms, behave in a responsible manner, take responsibility for herself and her baby, and live a responsible life in freedom and with responsibility (Heyns, 1974:81; Murrayand Smit, 1975:11-23).

- Because all dimensions obtain meaning only in conjunction with other dimensions and stand in unity with each other, the mother never acts according to one dimension only (although she chooses her body during birthing) and is therefore bodily-emotionally-spiritually involved when giving birth to her baby, as her actions always finds meaning outside

herself. Thus, the mother lives a fulfilling life and through her husband/partner, children, family, friends and helpers seeks self-fulfillment as human being, wife and mother. The mother, therefore, does not exist for the sake of existing as her existence is the answer to her task commission (Heyns, 1974:151).

- The mother has her own life history (a past, a present and a future) as she became what she was in the past and what she wants to be in the future, while she forms herself constantly in the present with the future in mind according to the norms of humanity from what she was in the past. Thus, the birthing mother will always change as she strives to become the person that she wants to be in the future. This affirms that the birthing mother is a human being, unrepeatable and unique possessing abilities, qualities and possibilities that are different from those of others because the birthing mother gives meaning to her life situations in her own particular manner and constitutes her own life in her own particular way (Nel *et al*, 1965:111 and Meyer *et al*, 1997:566-569).

■ The mother in relation to her fellowmen

- The mother as a human being is in her origin inseparably concerned with her fellow-humans yearns a community in whom she finds an alliance, fellow sufferers and fellow-assistants, and to whom she can be connected. Through and in her fellow human beings, the birthing mother discovers herself – therefore, the mother yearns to surround herself with family members and friends (even if they are unskilled helpers) that are familiar to her when giving birth to her baby as she can connect to them. And through them (her family members and her friends) she is socialized into the role of wife and mother and learns from them the norms and values, attitudes, beliefs, habits and customs that are acceptable when pregnant,

giving birth and parenting her child (Oberholzer,1970:30 and Louw *et al*, 1984:54-64).

- Within her household circle, marriage and family life-circle, the mother lives an intimate life with others. In her marriage affinity she becomes a wife and is as a wife more than what she previously was and in parenthood her being unfolds as a mother, becoming more than just a wife and spouse. Parenthood brings a permanent bond and relationship between father and mother, on the one hand, and among father, mother and children, on the other hand. Parent and child mould each other's personalities and parent-child-relationship (mother-child-relationship) is an important formative element in the development of the child's personality (Congalton, 1976:82-89).

- From the time of birth, a special status is imparted to the mother and throughout her life the mother stands in a certain position to other people. About her credited status the mother cannot change much, although she can bring changes through her membership to voluntary groups. All mothers explores the world in the milieu/environment of their specific social class and they learn class specific ideas and values and norms (concerning pregnancy, birthing and parenting) according to the prescriptions of their respective groups while conducting their lives to the standards of their group.

■ The mother in relation to the world

The mother as a human being lives in both the physical/concrete world and the socio-cultural world constituted by the members of the group she belongs to. She also lives in the psychological world of her own making. Because the mother actualizes herself in the living world, the area where her life drama takes place and her existence is executed, every mother constitutes her own

psychological world. This living psychological world is the totality of all the relationships the mother ties and all the meanings she gives to her experiences. The constituted living world grounds the becoming of the mother as she actualizes herself as a human being through her motherhood in conquering the world with horizons that ripple further and further outwards. Because the mother's living world is always multi-dimensional in nature, the mother experience her life in a historical way (past, present and future), in a spatial way (boundaries and horizons), and in a positive or negative way (experiencing a positive or a negative birth outcome). The mother actively inhabits her living world/living-space that stays secure, recognizable and possessively interpretable to her and according to the contents of the landscape of her living world she is a family person, a recreational person, a parent, a wife, a church person, a cultural person, a birthing mother, an ill person, a healthy person and a dying person (Nel *et al*, 1965:107-113).

■ The mother in relation to a Supreme Being

The mother lives her life in relation to her God/Supreme Being and because the Supreme Being talks to her and claims her in full, she must answer in faith, obedience and love or slander. In this dialogue between (in relationship with) God and mother, the Supreme Being touches the mother in her deepest being and the mother therefore directs and surround her life and being from an orientation point that soars above her (Heyns, 1974:81-89). The mother thus has a need for spiritual support and therefore family and friends around the birthing mother would pray with her. Religion provides a purpose for living and brings meaning and fulfillment to spiritual wellbeing. When the mother is isolated from her spiritual support system it increases her feelings of loneliness and isolation resulting in a negative birth experience (Kitzinger 2000: 30).

The mother as a cultural being

- The mother lives in a socio-cultural world according to the ethos of her specific culture. Her way of life (language, knowledge, faith, laws, practices, beliefs and habits) is rooted in and defined by her culture (Samovar & Porter, 2000:58). According to Peoples and Bailey (1991:21) all mothers internalizes from childhood onwards the cultural values, norms, thoughts, feelings and behavior of the specific groups they belong to. As a member of a specific group, the mother directs her behaviour according to the rules that were laid down by her culture. These rules (norms) whether formal (laws and written regulations) or informal (habits, traditions, taboos and customs) determine how she should behave in her community (van Staden & du Toit, 1998:41). The informal norms are more permanent and change very seldom and because these informal norms are as binding as the formal norms, deviation from the informal norms is met with specific punitive measures applied by the community. Hence, the pregnant/birthing mother's own mother or mother-in-law, as head of the household, makes the final decision, for example, where the mother has to give birth. Because mothers pregnant with their first born and pregnant teenagers have no previous experience of birthing they can never choose where to give birth - they have to listen to their elders and obey them otherwise the support from the elders will be withheld. Thus, adherence to cultural practices is extremely important to safeguard the unity of the family and to keep evil at bay.

- Culture as such creates a specific perspective of the world, a world view by which is attempted to understand the nature and give meaning to all events and processes in the world as well as to explain and understand life in general. And because the world-view directs humanity's understanding of the world, it is reflected in cultural convictions, cultural patterns that are being followed and in conduct of its members (Peoples

and Bailey, 1991:17-25). As the pregnant, birthing and lactating mother needs to be socialized into motherhood and parenting, it is culturally the birth attendant's task to provide culturally familiar ways of explaining pregnancy, birthing, and lactation to the mother and resolve any problem with culturally specific rituals and/or treatment. This empowers the mother because she is not a passive participant in the birth of her baby and her socio-cultural needs are fulfilled (Sesing, 1999:30-38).

As a human being the pregnant, birthing, lactating mother's dialogues (relationships) and talents are unique to herself and as a birthing mother she gives her own specific meaning to the birthing experience and has to work from out her "Self" through this life experience. The birthing mother must thus not only create her own safe place to live a meaningful life with her baby and her family but must also become the person she wants to be, must be and should be. Therefore, to support the mother to become what she wants to become as woman and as mother and wife, the maternal health care that has to be rendered must satisfy the mother and her family. To achieve this end according to Leininger (1979:30-31), care rendering must be according to the mother's cultural beliefs, convictions, norms and values, health behaviour and multi-dimensional lifestyle/pattern.

2.3 THE CARE TO BE RENDERED TO THE BIRTHING MOTHER

2.3.1 A historical overview

Historically birth outside a health facility (home) is not something new. According to Kitzinger (2000:8) since the beginning of time and in all cultures across the world, women have given birth amongst persons they know. Birthing women usually choose their own homes where they were supported by family members,

friends and helpers. According to Richter (1994:4) the family togetherness contributed to an experience of love and support that gave the mother courage and strength to birth her baby into the world. Thomas (2000:16) explains that certain family members (especially the mother-in-law or the own mother) had the responsibility of identifying the birth attendant – an older woman who was either from within the family (a wised family member) or from outside the family (a traditional birth attendant). Because the skills of this chosen birth attendant were known by the family, the chosen birth attendant was trusted to guide the birthing mother through the process of birth safely. One of the functions of the chosen birth attendant was to give information about the progress of labour by allowing the mother to choose what is right for her as well as reporting back how the mother is physically and emotionally coping with the birthing process. These actions and involvement of the birth attendant and family members empowered the mother to take control of the birth process. This practice of home birth is also noted by Wick (2002:2) who stated that up to fifty years ago, most births in Palestine took place at home, just as it was centuries ago. The labouring woman was assisted by respected and experienced women in the community called "dayas" or traditional birth attendant (TBA).

Prior to 1844, according to Moji (1993), there were no hospitals and medical services in Lesotho. Because there were no licensed midwifery practitioners (nursing and medicine) in Lesotho, the Basotho women called in traditional birth attendants when birthing as the practice of attending to birth and other medical illnesses were entirely in the hands of traditional medicine men and herbalist's women. The period 1844 to 1874 marked the beginning of modern medicine in Lesotho when two private practitioners arrived in Lesotho to serve the Basotho's. Although some pregnant women started to attend the provided ante-natal care services, they eventually gave birth at home attended by the traditional birth attendant as there were no birthing facilities. In 1875 the British Government in Lesotho got involved in the medical service delivery in Lesotho with the result that there was an influx of medical doctors from England as well as from South

Africa (there were no trained and licensed Basotho medical doctors) seeking employment in Lesotho. The Government employed these doctors and deployed them to various districts of Lesotho to serve the communities (Moji, 1993). Moji further states that in the late 19th and beginning of the 20th century, medicine and medical care in Lesotho became very popular and to give birth to a baby under the supervision of a doctor became a symbol of wealth. Birthing practices in Lesotho now started to echo the birthing practices in the western society, namely, giving birth in hospitals under the expert attendance of a trained and licensed doctor assisted by a trained and licensed midwife (Kritzinger, 2000:19).

With the rapid development of the medical and health sciences in the 18th and 19th centuries, the biomedical model of care developed as the result of the influence of science on the treatment of illnesses. According to this model of treatment, health is seen as the total absence of disease and treatment focusing on the malfunctioning of the cells of the human body, relegating the individual, the sufferer from the illness, to a bystander (Dolan, 1968:63). This resulted into the treatment of disease rather than the person as a human being (Gilbert, Selikow & Walter, 1998:16). Over the years, the biomedical care in medicine gradually spilled over to maternity care (Mathew and Zadak, 1997:3), resulting not only in the bio-medicalization of birth with the movement of birth from home to hospitals, but also the point of departure that pregnancy and birth is an illness that needs to be managed under medical supervision... Practitioners trained according to the bio-medical model of care, tend to concentrate their care on the physical body of the mother as the aim of the care rendering process. This process aims to investigate, diagnose, manipulate and control the events of birth by doing vaginal examinations and continuous fetal heart monitoring for example. Today, midwives in labour wards in hospitals render care by manipulating and controlling the birth process, forgetting that the mother also needs psycho-socio-cultural care because of technology's ability to create dramatic results. Because of this over-emphasis on technical care, midwives tend to neglect basic core principles like providing comfort and support. Many midwives do not always

ensure a clean bed for the mother, nor fulfill the mother's basic hygiene needs after birth, like giving a bed bath after birth, nor empowering the new mother with the necessary skills to care and parent her child. Mathew and Zadak (1997:3) further state that during the 19th century many mothers in hospitals died because of infection as some doctors did not wash their hands before attending to the birth process and because of the overcrowding of wards with not enough staff available to attend to the mother's physical needs. Mothers are also isolated from support from their family members as family members and friends are not allowed in the hospital according to hospital regulations and policies regarding visiting times. Some of these practices are still practiced in the 21st century namely, the isolation of mothers, overcrowding of wards, lack of staff and unhygienic conditions in labor wards.

Licensing of midwives is not a new concept as the church started to license midwives during the late middle ages. Although midwives in Europe had to be licensed from the 16th century, midwives in Lesotho only needed to be licensed from the beginning of the 20th century. Another point of importance regarding the licensing of birth attendants, as stated by Pigg (2000:23), is the move of the Jordanian government in the 1950's to license the "dayas" in order to train and supervise them and to legally compel them to report the births conducted by them. By legally compelling training and supervision as well as reporting the outcome of the birthing, the government of Jordania raised the standard of care rendering to the pregnant, birthing and lactating mother by checking whether the "dayas" were really doing what they were supposed to be doing, namely, conducting a birth safely and identifying the outcomes of birth (whether positively or negatively) as well as whether they adhered to their training when experiencing problems.

The birth outcome as an indicator of the care rendered

Every pregnant, birthing and lactating woman, regardless of her ethnical and cultural orientation, is the most important person in the care rendering process. To support the mother to become what she wants to become as woman and as mother and wife, it is of crucial importance to render maternal health care that satisfies the mother and her family. To achieve this end, the kind of care to be rendered must be according to the mother's cultural beliefs, convictions, norms and values, health behaviour and multi-dimensional lifestyle/pattern (Leininger, 1978:30-31). Leininger further states that if the birthing mother does not receive cultural congruent maternal health care (as nursing care), the mother experiences cultural imposition leading to cultural shock, cultural conflict and cultural clashes between the birthing mother and the birth attendant. Because the mother participates through her feelings in the birthing situation, the mother's emotions give meaning to her experience of the birthing process which in turn influences her behavior to her baby, her family and to her supporters. When the mother experience the birthing of her baby as satisfying and the care rendering as empowering and uplifting because her needs were fulfilled, the birthing process had a positive outcome for the mother. If the mother experiences a negative birth outcome, she feels uncomfortable and hurt to a point where she will avoid a repetition of the same situation in future.

To ensure the best possible birth outcome for all mothers and their babies, the following aspects must always be taken into consideration:

- Not all mothers' birth experiences in hospitals are negative. According to Jeffrey (1985) positive birth outcomes can be achieve in hospital as hemorrhage can be easily managed in hospital and excessive blood loss during and after birth should be uncommon under good medical

supervision. Mothers with obstructed labour can have a caesarian section done timeously and in cases where the perineum do not stretch, an episiotomy can be done and sutured. Because hospitals have central heaters and incubators for small babies, small babies do live and do not die of hypothermia - an important fact in Lesotho where it is very cold during the winter months.

- To prevent mothers experiencing negative birth outcomes in the hospital because of the absence of supportive care (comfort care) which is neglected due to the over emphasis of procedures (Kitzinger, 2000:208), the care rendering in the hospital must echo the supportive care given at home by family members and unskilled helpers. Field (2004) states that at home comfort care is provided by massaging and touching the mother in pain which then conveys a message of sympathy and understanding as touching and massaging having been used during labour in all cultures since time immemorial. Levy (2005) states further that the feeling of satisfaction and comfort the mother experience when having been in control of the birthing process, is not only a positive sign that birthing was a success, but also results in the mother feeling responsible for and behaving responsible towards her child as she feels honored to become a mother. The same author also states that the mother feels relaxed, comfortable and safe in the company of her family at home as they are not strangers to her as nurses and doctors in the hospital – therefore doctors and nurses need to engage with the birthing mother within the mother-provider-relationship as to ensure a positive birth experience in hospital.

- According to Endevours (2008 on-line) it is not uncommon for mothers who previously had experienced a traumatizing birth (whether in hospital or at home) to feel a mixture of anger, fear and panic. These feelings might not always surface right away or the mother might not been able to acknowledge these feelings out of concern that they are abnormal.

However, deep down the mother may be struggling with residual unresolved feelings and because these feelings are real for the mother, they may have a profound impact on whether the mother wants to become pregnant again or give birth in hospital/at home.

- Wick (2002) also states that the environment in health care facilities does not allow any family involvement as to provide support to the mother during the birthing process. The honouring of cultural practices is also not allowed in hospital because health care personnel are not trained to include cultural practices as part of a positive birth outcome. The honoring of cultural birth practices contributes to a positive birth outcome as the mother does not develop a sense of guilt or shame, but feels satisfied and at ease with herself. Cultural practices like the burial of the placenta by selected persons e.g. the grandmother as to prevent witchcraft; seclusion of the mother for a period of more or less ten days, the burning of herbs and exposing the newborn infant to the smoke as a protective and cleansing ritual and many others, forms a big part of the birthing process - whether in hospital or at home.

- Although mothers usually plan before hand where they are going to give birth to their babies, either at home or in a health facility, it can sometimes happens that their babies are born unexpectedly in an unplanned place because of reasons such as premature or precipitate labour or because of the unavailability of transport to the hospital. The birth outcome of a planned birth either at home or in a health care facility is, according to Myles (2001:38) usually good, but an unplanned birth outside a health facility has a high rate of complications like postpartum haemorrhage, obstructed labor or vaginal fistulas. According to Ateka (2000) uncontrolled pushing on a distend perineum that tears raggedly results in a negative birth outcome when unassisted birthing had occurred outside the health care facility. Both Myles and Ateka further state that women

who are alone at the home during childbirth tend to have stress moods and panic attacks as the outcome of the birth process because they were unsupported.

- A well mother and baby, according to Pony and Hefelfunger (1999), is not the only factor that determines a positive birth outcome, the sex of the baby also plays an important role in the positive outcome of childbirth as most husbands prefer the first born to be a boy because a boy can carry on the family name and care for parents in their old age.

- Although most families experience a healthy childbirth in hospitals and at home, any poor birth outcome results in financial devastation for the family as they cannot always afford to neither pay for long periods of hospitalization of the newborn nor provide the necessary fees for the care of their disabled child in later life (O'Connor, 2004 on-line).

- According to Davis and Helewa (on-line), in a study of 5 418 pregnant women assisted by certified midwives in North America during birth, home births were safe and comfortable leading to a positive birth outcome for the family as a unit. Furthermore, these birthing mothers also needed less medical intervention and fewer episiotomies.

- In most health care facilities, medical interventions such as vaginal examinations, the induction of labour, the administration of oxytoxin to augment/induce the birth process and the performing of routine episiotomies are still practiced routinely - interventions that can result in a negative birth experience due to infection or the increased pain the mother experienced or even uterine rupture (Dujardin, 1995 and Kitzinger, 2000:19). Louis and Martel (2003:48); Hardar (2005:102) and Hoffmeyer (2005), on the other hand, state that the majority of birthing mothers do

not need interventions during birth because to give birth is a natural physiological process.

- A positive birth outcome in either the health facility or at home is largely dependent on the presence of a skilled helper who knows what she is doing during the birth process and who can identify and detect emerging problems that require further care (WHO report, 2000), for example, in the hospital when there is a delay in second stage due to a tight perineum, a skilled helper is able to cut and suture the perineum. According to Mackey and Williams (2000) when a home birth is planned the outcomes can be positive, however due to unforeseen circumstances birth outcomes can be negative even in health facility.

- Although the newborn baby can be adequately resuscitated under medical care in the health facilities when need arises, the biggest factor that leads to a negative childbirth outcome in health facilities is the procedure of separating the newborn from his/her mother, as newborns are kept in a nursery. This hospital policy/procedure disrupts the mother-child-bonding-relationship as well as depriving the baby of skin to skin contact with his/her mother (Levy, 2005). However, according to Helmerhost and Denis (2000), this negative birth experience can be altered to a positive birth experience by keeping the baby between the breasts of the mother as this procedure provides not only natural warmth for the baby but also promotes mother-child-bonding as well as breastfeeding.

- Based on the point of departure of the biomedical model that view pregnancy, birthing and lactation as an illness/disease, the mother in labour is treated as an ill person in the hospital. Thus, the birthing mother is subjected to many technical procedures like taking her blood pressures and temperature, doing vaginal examinations and many other routine activities during the birth process. As result, the birthing mother is not

relaxed and due to her stress, her labour does not progress. The birthing mother at home is, in contrast, more relaxed; show better labour progress and less breastfeeding problems occur after birth. Because the birthing mother is not kept nil per mouth at home as in the hospital, the birthing mother at home eats when feeling hungry and drinks ample fluids when feeling thirsty – a situation that not only provides the mother with the necessary energy during labor but also increases the flow of her breast milk after birthing. As the baby is mostly put to the breast on demand at home, the risk of post-partum haemorrhage is lowered due to the fact that breastfeeding helps the uterus to physiological contract more quickly. The pattern of breastfeeding-on-demand also helps to create a quality mother-child-relationship due to the deep bonding that takes place between a happy mother and her baby - a closeness and deep love shared between mother and baby. Because of the policy of the separation of mother and baby and four hourly feeding pattern this deep mother-child-closeness is some times difficult to establish early in the newborn's life (Mackey & Williams, 2000).

- Regardless of the high recognition gained by the medicalization of births, mothers are not satisfied with the care they received. Most birthing women in many developing countries as well as in Lesotho complain bitterly about overcrowding in hospitals, the lack of cleanliness of the wards, the lack of privacy and the lack of caring given to them in labour as many health care attendants do not respect them as human beings, scream at them, leave them alone for periods of time and refuse to support them psychologically (Mathew & Zadak, 1997:35 – 45 and Mohai & Thahane, 2000). As such, both Wick (2002:14) and Moji (1993) indicated that affordable maternity care in health care facilities (public and private) together with the fact that to give birth in the hospital was viewed as a symbol of wealth, led to the streaming of birthing mothers to health care facilities/hospitals for the birth of their babies. This movement

resulted in the overcrowding of hospitals where there is not enough skilled nurses, midwives and doctors as well as equipment to care for pregnant, birthing and lactating mothers. Because of this overcrowding in hospital wards, according to Dujardin (1995), mothers have to share beds, linen are not clean and some mothers even have to sleep under beds. The above mentioned author also indicated that in hospitals various health workers carry foreign microbes against which the mother has no natural resistance - increasing the mother's risk for infection when admitted to hospital. In contrast to the previous, births at home results in fewer infections because the environment is clean, less interventions take place during the birthing process and less pathogenic microbes are introduced by familiar persons.

- Because of the bio-medically oriented care rendered by health professionals in the health care facilities, cultural practices as well as the involvement of the family are neglected. According to Wick (2002:112) family involvement creates a loving environment by acceptable known people who encourage and support the mother in labour. Family involvement also guarantees continuity of care and support to the mother and newborn. Involvement of the family also ensures that all cultural practices regarding pregnancy, birthing and lactation as well as all cultural beliefs and practices involving mother and newborn are honoured. The importance of these practices must never be minimized because it exposes both mother and baby to the new way of life in her family and shows the mother how to naturally care for her newborn baby and herself without involving outside resources.

In summary it can be stated that many mothers, because of their lived negative birth experiences or due to the fact that they have culturally no choice regarding the place of birth or because of other reasons known to the mother herself, give birth outside health facilities. According to the World Health Organization (WHO-

report, 2000) births at home can be made safer for many mothers if they receive appropriate antenatal care before child birth. Antenatal care is an opportunity for the skilled health provider to take an obstetric history of the mother, to assess the mother for risks, to detect and treat the mother for diseases she suffers from like anaemia and to immunize the mother against Tetanus. As such, the antenatal assessment of the mother is an important screening process to detect possible risks that can complicate the birthing process at home and to use the findings in advising the mother to give birth in a health facility rather than at home. Antenatal care is highly regarded and respected by pregnant mothers in Lesotho, hence the 95% antenatal attendance. However, less than 50% of mothers who attended antenatal care give birth in health facilities – the other 50% of mothers give birth either at home or in unknown places along the way to a health facility (MOHSW, 2004).

2.4 STRATEGIES TO IMPROVE THE BIRTH OUTCOME FOR THE BIRTHING MOTHER

The maternal death rate in Lesotho is 762 per 100,000 live births and the neonatal death is 93 per 1000 live birth. (Ministry of Health and the Bureau of Statistics, 2004). According to Ateka (2000) the maternal and neonatal mortality rates could be much higher if a reporting system exist that includes the official reporting of all birth outcomes at home. Although most pregnant mothers in Lesotho attend ante-natal care facilities that are provided by skilled attendants, not all of these pregnant mothers give birth at the health care facility (MOHSW, 2004). To address maternal and neonatal mortality and to improve the rate of hospital births, various strategies (of international and national origin) were implemented in Lesotho like the Safe Motherhood Initiative, the creation of primary health care (PHC) services as to improve the availability of skilled helpers on community level and the provision of training for skilled and unskilled attendants.

■ Safe Motherhood Initiative (SMI)

According to the World Health Organization (WHO, 1996) the Safe Motherhood Initiative was launched in 1987 as a global effort to reduce maternal mortality and morbidity. The Safe Motherhood Initiative is the outcome of the unique partnership of international organizations working together to raise awareness of safe motherhood, to set priorities and stimulate research on maternal mortality, to mobilize resources and to provide technical assistance for the safe caring mother and newborn, and to share information according to each organization's mandate and objectives. The international organizations in partnership are: United Nations Development Programme (UNDP), United Nations Children Fund (UNICEF), United Nations Population Fund (UNFPA), the World Bank, World Health Organization (WHO), International Planned Parenthood Federation (IPPF) and the Population Council. Their cooperation and commitment have enabled governments and non-governmental parties/partners from more than 100 countries to take action as to make motherhood safe for mother and child. Lesotho, as such, is one of these countries involved in making motherhood safe in and outside health care facilities.

The Safe Motherhood Initiative aims to enhance the quality and safety of the lives of girls and women through the adoption of a combination of health and non-health strategies. The Initiative places special emphasis on the need for better and more widely available maternal health services, the extension of family planning, the education of girls and women, and the creation of services and effective measures aiming to improve the status of women in general.

According to Ministry of Health and Social Welfare (2000), the Lesotho Safe Motherhood Initiative aims are as follows:

- Political commitment and financial support to support safe motherhood by the govemment of the day. To achieve this aim all parliamentarians were informed about the alarming mortality rate of mothers and newboms in and outside health care facilities in their respective constituencies. They were also informed about the need of more health care facilities and skilled staffing, especially in the remote areas needed support and security to continue servicing communities. Water sources in the village also needed to be protected and roads must be upgraded and rehabilitated as to make health care services accessible for all health care users, especially pregnant, birthing and lactating women.

- Commitment of community leaders for safe motherhood as to increase the commitment of all citizens (both male and female). Workshops needed to be held across all health districts as to identify the roles to be played by community leaders, males and females in the provision of a safe environment for the mother and newborn in and outside health care facilities. The role and training of traditional birth attendants also needed to be discussed so that they could provide a safe and positive birth outcome during the birth process outside health care facilities.

- Motivation of mothers to attend antenatal care facilities before birthing. To achieve this aim, both community leaders and parliamentarians were requested to motivate all women in their communities/constituencies, especially pregnant mothers, to seek and attend antenatal maternal health care before birthing as well as to keep the obstetric record given to them at the health facility safe and present it at any health facility they attend as to ensure continuity of care.

■ The creation of primary health care centres and safe staffing of health care facilities

According to the Lesotho health care system, three levels of health care service delivery exist that are interdependent and inter-related, namely, the community level, the district level and the national level. The district health care system forms the point of departure for the national health care system and the health care service delivery system is based on the principles of primary health care as defined in the "Declaration of Alma Ata". According to the "Declaration of Alma Ata" (1996) primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-determination. By implementing the primary health care strategy and principles by creating enough health care centers the accessibility and availability of health care to all citizens on community level is greatly enhanced in Lesotho. Through this strategy it is hoped that all mothers will give birth in a health facility or under the supervision of a skilled helper in the rural areas who is available to assist mothers who cannot go to a health facility. The reason why birthing must take place under the supervision of a skilled attendant is that when complications during birth set in, the skilled attendant is able to assist the mother and if necessary refer the mother to a hospital for more advanced care.

According to the District Health Care system, the communities will be served by primary health care clinics/community health care centers which will provide comprehensive primary health care according to the policy and programmes of the district. A referral system exists between the community services, the health care centers and the hospitals on national level. The service delivery is

integrated and the health care user can be referred or transferred between the different points based on the type of service delivery needed as to render holistic, comprehensive and culturally congruent health care to the health care user and his/her family. On community level, health care service delivery is provided by community health workers (CHW), traditional birth attendants (TBA) and traditional healers (TH). On district level, health care service delivery is provided by skilled professional nurses and other health care members in health care centers (although some health centers are run by semi-skilled nursing assistants with insufficient midwifery training). Health care users are referred by community workers to the health care centre. On national level, health care service delivery is provided in hospitals by all skilled professional health care providers – doctors, midwives and other health care members. Health care users (pregnant and birthing mothers) are referred from health care centers to hospitals when the mother and baby need more advanced maternal and infant services because of complications. Procedures like assisted birth such as caesarian section and infant resuscitation under medical care can only be performed in hospitals (Ministry of Health and Social Welfare, 2000).

According to a report of the World Health Organization in 2004, the demand for more skilled helpers and more hospitals is extremely high in many developing countries – including Lesotho. At present, according to the Department of Health and Social Welfare of Lesotho, there is a shortage of midwives in Lesotho as many professional midwives resign from the public health care delivery system. The remaining midwives have to care for all mothers and babies with the help of semi-skilled attendants (nursing assistants) who are not trained to provide comprehensive, holistic, culturally congruent and compassionate care as they have to work under the supervision of the professional midwife. As the semi-skilled attendants are also not trained to provide pregnant birthing mothers with the appropriate information and advice that promotes participation and facilitates informed decision making, the work load of the professional midwife increases/enlarges resulting in the resignation of professional midwives. The

World Health Organization suggest that to meet the demand for the rendering of holistic, comprehensive and culturally congruent health care to the birthing mother and her family a blended model of care rendering must be established that is characterized by the best of the biomedical model and the best of the traditional holistic model being integrated with one another. This point of departure will ensure safe staffing for the caring for the mother and her baby as skilled attendant and traditional birth attendant shall work together for the sake of a healthy nation. The time it will take to implement the blended model will depend on the capacity of each health care system to train and appoint both skilled and unskilled attendants and the funding available for this specific purpose.

■ Implementing the goals of the Millennium Declaration

Lesotho government is signatory to the Millennium Declaration adopted in 2000 by 189 member states to the United Nations. The declarations sets out key challenges facing humanity, outlines responses to these challenges and establishes concrete measures for assessing service delivery performance through a set of inter-related goals on development, governance, peace, security and human rights. There are 8 millennium goals set but of particular concern in thus study are goals 5 and 6 that deal with the reduction of child mortality and improving maternal health.

➢ Reduction of Child Mortality

According to the Ministry of Health (2004:113) the information on the rates of and causes of mortality in children serves, the Health Ministry to identify groups of children who are at high risk to die before reaching adulthood. The infant and child mortality rate also serves as an indicator reflecting the degree of poverty and deprivation of population as a whole. As such, Lesotho as a signatory of the

Millennium Declaration had made high gains in child health since 2000 as it is recorded that 66% of all children born are fully immunized. These fully immunized children, aged 12 – 23 months, are now less susceptible to childhood diseases like tuberculosis, polio, diphtheria, whooping cough, and measles. Unfortunately, the infant mortality rate in Lesotho is still as high as 93 per 1000 live births and more measures and programmes needs to be put in place as the mortality rate has to be reduced by two thirds between 1990 and 2015 (Millennium Goals).

➢ Improving Maternal Health

The Lesotho government (2004:15) states that the maternal mortality is a tragedy in social, economic and public health terms. The Lesotho maternal mortality was in 2004, 762 per 100,000 live births and needs to be reduced by three quarters from 1990 to 2015 (Millennium Goal). Presently, no current maternal mortality rate statistical information exists because of the lack of resources and/or not having enough personnel to do the work. According to the same report of the Lesotho Government (2004:16), adolescent girls and boys in Lesotho become sexually active at around age 12 -13 years without any preparation regarding sexuality and contraception. By the age of 15 years most of these adolescents have regular, often unprotected premarital encounters leading to unwanted pregnancy, pregnancy related complications, sexually transmitted infections and unsafe abortion. These young adolescent girls are consequently at greater risk of dying during birth than women who are in their twenties and thirties.

In an effort to improve maternal and neonatal health in Lesotho, new health facilities were constructed at district level to make the delivery of health care to pregnant, birthing and lactating mothers and babies more accessible and affordable. Programmes to recruit qualified staff have been put in place to ensure safe staffing, and the in-service training departments of care facilities have been updated and professional workshops to update staff with new skills

are being organized. It must also be mentioned that, although the abovementioned strategies to improve maternal and child health are in place, they are not sustained for long periods of time.

2.5 EDUCATION OF PROFESSIONAL MIDWIVES AND TRADITIONAL BIRTH ATTENDANTS.

In order to render compassionate, comprehensive, culturally congruent and holistic care to pregnant, birthing and lactating mothers (of all ages and of all cultures) and their babies, all professional midwives and all traditional unskilled attendants must be educated in the science and art of midwifery. All midwives need to be competent, knowledgeable and skilled in midwifery and maternal and neonatal health as to render the best care possible to mothers and their babies. The content and context of the curriculum for the professional midwife or skilled attendant is set by the statutory body that regulates the scope of practice of the midwife as well as license the midwife to practice midwifery.

The cultural practice of birthing at home while attended by family members and a non-professional attendant is still practiced in the 21st century. Most of the time the unskilled attendant only receives an informal education in an apprenticeship way as it is a shared and learned education from generation to generation to care for the mother and her baby. The informal education of the traditional attendant include topics such as the importance of supporting the mother; the advice given to mothers, the herbal medicines that can be administered to the mother during pregnancy, birthing and lactation; the rituals and practices to be performed to protect mother and baby as well as cleansing them; and practices to follow during the birthing process. Novice birth attendants start learning by observing the trained traditional midwife and may only practice independently after mastering the practice of maternity care (Sesing, 1999:28-30). Because no core education and skills is set for the education of the non-professional/traditional

birth attendant, the education of the professional/traditional birth attendant needs to be formalized as to ensure that best care is rendered to mother and baby.

➢ The education of the professional midwife

The educational programme of professional midwifery has the aim to ensure that all midwifes are able to render compassionate, comprehensive, culturally congruent and holistic care to pregnant, birthing and lactating mothers of all ages and of all cultures. The curriculum for the preparation of professional midwives consists of a system of learning designed to provide compassionate, comprehensive, culturally congruent and holistic to pregnant, birthing and lactating mothers and to promote the health and welfare of mother, child and family. The International Confederation of Midwives (ICM, 2005), on the other hand, declared that the education of midwives must be based on the philosophy and model of Midwifery care outlined as follows: "Midwifery care consists of an art and a science. Midwifery care is holistic in nature, grounded in an understanding of the social, emotional, cultural, spiritual, psychological and physical experiences of women and is based upon the best available evidence". The ICM states further that the midwife is recognized as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and post partum period, to conduct births on the midwives own responsibility and to provide care for the newborn and infant.

According to the WHO (2004:3) the education of midwives should prepare the midwife to possess the core midwifery skills and abilities to perform all of the following functions:

- Communicate effectively cross cultural in order to be able to provide holistic "women centered' care.

- In pregnancy care, take a detailed history by asking relevant questions, assess individual needs, and give appropriate advice and guidance.
- Assist pregnant women and their families in making a plan for birth (i.e. where the birth will take place, who will be present and in case of a complication, how timely referral will be arranged).

- Educate women (and their families and others supporting pregnant women) in self care during pregnancy, childbirth and the postnatal care.

- Identify illness and conditions detrimental to health during pregnancy, perform first line management (including performance of life saving procedures when needed) and make arrangements for effective referral.

- Perform vaginal examination; ensuring the women's and her/his own safety.

- Identify the onset of labour.

- Monitor maternal and fetal wellbeing during labour and provide supportive care.

- Record maternal and fetal wellbeing on a partograph and identify maternal and fetal distress and take appropriate actions including referral where required.

- Identify delayed progress in labour and take appropriate action, including referral where appropriate.

- Manage a normal vaginal birth.

- Manage the third stage of labour actively.

- Assess the newborn at birth and give immediate care.
- Identify any life threatening conditions in the newborn and take essential life saving measures including where necessary active resuscitations a component of the management of birth asphyxia and referral where appropriate.

- Identify haemorrhage and hypertension in labour provide first line management (including life saving skills in emergency obstetric care where needed) and if required make an effective referral.

- Provide postnatal care to women and their newborns and post abortion care where necessary.

- Assist women and their newborns in initiating exclusive breastfeeding, including educating women and their families and other helpers in maintaining successful breastfeeding.

- Identify illness and conditions detrimental to the health of women and / or their newborns in the postnatal period, apply first line management (including the performance of life saving procedures when needed) and if required make arrangements for effective referral.

- Supervise non-skilled attendants including TBA's where they exists in order to ensure that the care they provide during pregnancy, childbirth and early postpartum period is of sound quality and ensure continuous training of non-skilled attendants.

- Provide advice on postpartum family planning and birth spacing.

- Educate women (and their families) on how to prevent sexually transmitted infections including HIV.
- Collect and report relevant data and collaborate in data analysis and case audits.

- Promote an ethos of shared responsibility and partnership with individual women, their family members / supporters and the community for the care of women and newborns throughout pregnancy, childbirth and the postnatal period.

As such, the midwifery curriculum in Lesotho, as prescribed by the Lesotho Nursing Council, does comply with the abovementioned set content as prescribed by the World Health Organization. Due to the national health care needs of Lesotho, midwives need to be dual qualified, in general nursing and in midwifery, before they can be employed in the public health care service. The reason for this is the fact that, when professional nurses are deployed to the rural health care facilities, they work on their own without any medical support by doctors. Nurses in the rural areas have the responsibility to not only identify illness and conditions detrimental to health in general, but also to render antenatal, intra-partum and postpartum care. Furthermore, it is also expected of these nurses to perform first line health care management including the performance of life saving procedures and treatment when needed as well as make arrangements for effective referral. Ireland, Bryers, Hindley, Harris, Tucker & Caldow (2007) mentions that the medical practice in the rural areas of Scotland where "generalist" nurses provide midwifery care without specific midwifery skills, is duplicated in many other countries.

Presently the following educational programmes are offered in Lesotho as legalized under the Nurses and Midwives Act of 1998 and registered by the Nursing Council of Lesotho as a legal qualification obtained:

- A Diploma in General Nursing lasting 3 years at a Nursing College that is accredited by the Lesotho Nursing Council
- A Diploma in Midwifery lasting 1 year at a Nursing College that is accredited by the Lesotho Nursing Council after the Diploma General Nursing has been obtained.

- A Bachelor of Science degree in Nursing lasting 4 years at the National University of Lesotho and is accredited by the Lesotho Nursing Council. This programme integrates general nursing and midwifery

The educational programme for midwives are molded in the bio-medical model of care and due to their training philosophy nurse-midwives render care to the mother and child in a technical way. Because of this specific point of departure of the educational programmes, nurse-midwives tend to negate the holistic and socio-cultural dimensions of the mother as a human being. (Lesotho Nursing Council / 2007)

Professional midwives in Lesotho have not yet established an active midwifery forum under the auspices of the International Confederation of Midwives (ICM) as in Zimbabwe, Swaziland and South Africa. The International Confederation of Midwives (ICM) is a unique midwifery professional organization which plays a leading role in promoting safe motherhood in and outside health facilities. According to Herschderfer (2005) midwifery is gradually emerging as an essential element of safe motherhood. Obstetricians have come to realize that midwives can be of help to them. Three yearly, more than 2000 midwives from the world over attend the global forum "Midwifery pathways to healthy nations" to exchange knowledge and experience with those concerned with maternity, newborn and women's health care. According to Herschderfer, (2005) the International Confederation of Midwives (ICM) main aim is to better the education of midwives so that midwives render compassionate, comprehensive, culturally congruent and holistic care to pregnant, birthing and lactating mothers and their

babies. Because no forum exists in Lesotho, the International Confederation of Midwives (ICM) is not actively involved in Lesotho except for sending sometimes an invitation to attend the ICM forums - thus reminding midwives in Lesotho that the International Confederation of Midwives (ICM) can play a role in the uplifting of midwifery in Lesotho.

➢ The education of traditional birth attendants

Many mothers use the non-professional midwife (the traditional birth attendant) as helper during the birthing process because they are available, supportive and attend to their emotional, spiritual and cultural well-being. The education of the traditional birth attendant needs to be comprehensive to enable the TBA to render the best care to mothers and babies. The World Health Organization (2004:8) as such acknowledges that trained traditional birth attendants (TBA's) contribute to the welfare and health of mothers and babies in the community. According to the World Health Organization trained Traditional Birth Attendants can assist in the care of women and newborns by:

- Serving as advocates for skilled attendants by advocating for the health needs of mothers and newborns.

- Encouraging women to enroll for essential pre- and postnatal care and to obtain care from a skilled helper.

- Helping women and families to become self-caring and make recommendations about nutrition, treatment, dietary supplementation, immunization, keeping of scheduled appointments, and planning for birthing and the handling of emergencies.

- Encourage the involvement of the male partner in the care of the women and their newborn.

- Disseminate health information to community and families about danger signs during pregnancy, where and how to seek care in case of an emergency, healthy life styles, where to seek assistance for any reproductive health needs such as family planning, and neonatal immunization.

- Giving social support during and after the birth, either as a birth companion, for example, acting as a doula (a South African term for a specially trained women providing social support to women in labour) or by supporting the household while the women are away for childbirth.

- Informing the skilled attendant about pregnant women in the community, so that the skilled attendant can make direct contact with them.

- Serving as a link between families, communities and local authorities and the reproductive health services.

- Encouraging community involvement in the maintenance of the continuum of care.

The World health Organization (2004:9) further stress that, in order to have a viable programme for Traditional Birth Attendants, a functioning health system must be in place with suitable buildings, enough staff, the right mix of professional skills, satisfactory terms of employment, a referral system and a effective system of monitoring, supervising and training of staff as well as the supervision of the Traditional Birth Attendants by skilled professional midwives. But, although the Traditional Birth Attendants are human resources that can be developed with appropriate support, education and training, the Traditional Birth Attendants cannot replace the need for all women to have care from a skilled attendant also.

Although the formal training of Traditional Birth Attendants in Lesotho started in 1973, the curriculum and training were not standardized. In some health service areas the Traditional Birth Attendants were trained to assist mothers during childbirth while in other health service areas the Traditional Birth Attendants were only trained to do advocacy for mothers but discouraged to actually assist during the birth process. This training programme was externally funded by the World Health Organization (WHO); the United Nations Children's Fund (UNICEF); and the United Nations Fund for Population Activities (UNFPA). According to Maieane (1998) these donors provided vehicles, Traditional Birth Attendants' kits containing cotton wool, spirits, new razor blades packets, soap in dish, towel, cord clamp and cord ligatures small note book, pen and pencil. When the training programme was evaluated in 1996 (MOH 1996), it was found that the educational environment was not enabling the Traditional Birth Attendants as the Traditional Birth Attendants' kits were not refilled with supplies and commodities, some of the Traditional Birth Attendants did not have kits with the result that they could not function as expected. Traditional Birth Attendants also wanted to be paid a minimum fee for the work they were doing. The professional nurse-midwife at the health facility was not able to support and supervise the Traditional Birth Attendants at their work place. However, the nurse-midwife expected the Traditional Birth Attendants to come to the health facility with reports and individual questions. Due to lack of funds the training programme for Traditional Birth Attendants were not continued in government facilities. The Private Health Association of Lesotho is however continuing with the training of some of the Traditional Birth Attendants with funds from donors, especially in the rural areas.

2.6 SUMMARY

Through the ages women have been giving birth at home (outside health facility) but with the evolvement of the biomedical health care model and the medicalization of maternal health care, more and more women began to give

birth in hospitals where the care rendering emphasis technical care rather than holistic care in a personal way. Mothers, on the other hand, want to be more involved in the birth process of their babies – thus they prefer to give birth outside a health facility. Because skilled helpers are not always available at home, the outcome of birthing at home may not always be positive. Safe childbirth is not just a matter of medical care but is embedded in the social context, influenced by many factors like living environment and conditions, nutrition, education and the status of women. Therefore the aim of Safe Motherhood is not only to prevent maternal deaths, but also to empower women to make informed decisions regarding childbirth.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

The aim of the study is to describe births outside a health facility as a phenomenon in Maseru Health Service Area, Lesotho. A description of the research design, the population and sample will be given. In this chapter the data collection instrument and the data collection process, the validity and reliability of the whole study, as well as the data analysis process used, will also be described. Lastly, the ethical considerations, the problems encountered during the data collection process and the value of the study will be discussed.

3.2 THEORETICAL BASIS OF THE RESEARCH

In the light of the aim and objectives of the study a non experimental design with a descriptive and exploratory nature was used. The study is non experimental because the aim of the study is to explore and describe the phenomenon behind births outside health facilities. According to Burns & Grove (2001:223) a non-experimental design of a descriptive nature must be used when new knowledge is generated about a topic that has been limited or not been researched. As no previous studies have been conducted in Lesotho on births outside health facilities, the data obtained would be new, contributing to the descriptive and exploratory nature of the study. Since the description (information) of births outside health facility is a real life situation (human experiences) no other design was applicable.

3.3 THE RESEARCH METHODOLOGY

3.3.1 The survey

A survey method is about gathering information from a sample of the population intended merely to describe a phenomenon. The researcher does not manipulate any variables and there is no effort to determine the relationship between variables. The individuals are asked questions according to a standardized procedure regarding particular aspects with the intent of obtaining a complete profile of the population (Brink, 1996:110 and Laetus & Lategan, 2003:38). Therefore the survey was used specifically to explore births outside health facilities with the aim of describing it fully.

In this study the survey as a method was used because:

- Surveys can be used to collect information on women of all age groups regarding their actions, intentions, attitudes and values about births outside health facilities.

- A survey was a good method to use because there was a lot of sensitive information to obtain in this study on births outside health facility.

The instrument used in this research is a semi-structured interview with the help of an interview schedule. The semi-structured interview was used to:

1. Overcome prejudice because the questions in the interview schedule were constructed in such a way that the same questions were used for all the respondents. This helped to make the data collection process more uniform.

2. Eliminate the effect of any external influences that may have an effect on the response of the respondents. The researcher did all the interviews herself.

3. Instead of a questionnaire because of the flexibility of the structured interview which allows the researcher to explore births outside a health facility to a greater depth (Brink, 1996:158).

4. Increase the response rate due to the fact that some of the mothers may be illiterate (Burns & Grove, 2001:421 – 422).

5. Help of an interview schedule was used to control the content of the interview (Burns & Grove, 2001:230).

Open-ended as well as closed-ended questions were used. Open-ended questions were used to clarify information received or desensitize more sensitive information.

Homogenous stimulus was provided due to the fact that the same structured instrument was used for all participants (Burns & Grove, 2001:237).

3.3.2 POPULATION AND SAMPLE

In the definitions used by various authors Polit and Hungler (1997); Burns and Grove (2001) and White 2003) a population is the entire group of persons or objects or facilities that is of interest to the researcher or that meets the criteria the researcher is interested in studying.

The population, out of which the sample was selected, consisted of the population for the health facilities and the population for mothers who gave birth outside the health facility.

3.3.2.1 Health facilities

- **Population**

Maseru Health Service Area has a total of 31 health facilities/clinics. These health facilities/clinics do not offer the same services. Some offer one service, example: child welfare or family planning services only. Other health facilities/clinics offer outpatient, ante-natal care, intrapartum care, post natal care and family planning services all under one roof (comprehensive services). The population consisted of 31 health facilities.

- **Sample**

According to Burns & Grove (2001:185) and Laetus & Lategan (2003:114) a sample is a fraction or part of a larger set selected by the researcher to participate in a research. The sample for health facilities/clinics was selected as follows:

- **Randomised level**

A sampling frame of all health facilities/clinics that offer the following services, antenatal care, intrapartum care, postnatal care, well baby clinic and family planning services was made. A total of 9 health facilities/clinics were identified for the study because they were the only ones providing all those services mentioned above. Out of the nine health facilities/clinics one was used for the pilot study. Thus leaving the remaining eight solely for the entire study. The researcher selected the 8 health facilities/clinics purposely because these health facilities/clinics identified are known to be providing services that women mostly

need and the services are antenatal, intrapatum and post natal care including family planning and child welfare services.

■ Data level

On data level the sample for health facilities was purposefully selected because all the 9 health facilities included in the study provided maternal child health services.

According to Burns & Grove (2001:376) the sampling of health facilities was purposefully done to capture the richness of a wide range of perspectives. Nine health facilities/clinics were identified from town, peri-urban and rural settings to be included in the study and one was identified for the pilot study, as illustrated on table 3.1.

Table 3.1: Breakdown of health facilities by setting

Health facility	Town	Peri-urban	Rural
Bethany			√
Good shepherd			√
Holy family			√
Khubetsoana		√	
Makoanyane		√	
Matukeng			√
Qoaling Filter		√	
Queen Elizabeth II	√		
Maseru Private	√	For pilot study	

To determine the starting point, the following steps as described by Burns & Grove (2001:368) and Leady & Ormrod (2005:98) were followed:

- Names of the health facility/clinic were written on a piece of paper.
- Pieces were mixed in a hat and picked.
- The picked piece of paper with name of a health facility/clinic indicated the starting point. The starting point was at the Holy Family Clinic in the rural area. Thereafter the identified health facility/clinic in the rural area were visited for data collection. The peri-urban health facilities/clinics were visited for data collection after the rural health facilities/clinics and the urban area was the last to be visited for data collection until all health facilities were included.

3.3.2.2 Population of mothers

According to Ministry of Health and Bureau of Statistics (2004:130) the place of birth in the whole country for 45% of mothers was outside a health facility. This place of birth is regardless of a mother's age at birth, birth order of child, residence, ecological zone, district, mother's education, antenatal care, visits and wealth quintile.

The sample for mothers was selected as follows:

- **Population of mothers**

In Maseru Health Service Area, 8600 mothers gave birth outside health facilities during 2005 and they were the target population in the study. These study subjects had attended antenatal care during pregnancy, however did not return for the births of their babies and it is assumed that they gave birth in an unknown place as shown on table 3.2.

Table 3.2: Distribution of antenatal care attendances, births at health facility and births at unknown place during 2005 in the Maseru Health Service Area (Ministry of Health, 2005)

Health facility	Total no of antenatal care attendance	Births at health facility	Birth place unknown
Bethany	293	40	253
Good shepherd	573	11	562
Holy family	481	51	430
Khubetsoana	1128	904	224
Makoanyane	494	148	346
Matukeng	347	16	331
Qoaling Filter	2448	261	2187
Queen Elizabeth II	10 325	6058	4267
Total	**16 089**	**7489**	**8600**

Table 3.2 shows that the majority of mothers in the Maseru Health Service Area, 8600 (53%) gave birth in an unknown place.

Babbie & Mouton (2001:174) describe the population as an aggregation of elements from which the sample is actually selected. The sample on the other hand, according to the same authors is the number of elements of the population being studied. Leedy & Ormrod (2005: (a) 207) state that when the population is 10,000 or more a sample of 300 is adequate for a study; however because 8600 is the population of mothers who gave birth in an unknown place during 2005 a sample of 344 was recommended (Bureau of Statistics Maseru, 2003).
The attendances were of the same mothers with different visits during the antenatal period.

Randomised selection of mothers

A purposeful sampling of mothers was used to find subjects who meet the sampling criteria. The health facility/clinic nurse identified women who gave birth outside the health facility/clinic during 2005, and everyone who gave permission to participate was a subject for the study as shown on table 3.3.

Table 3.3: Number of participants for each health facility/clinic

Health facility	Frequency
Bethany	43
Good shepherd	43
Holy family	43
Khubetsoana	43
Makoanyane	43
Matukeng	43
Qoaling Filter	43
Queen Elizabeth II	43
Total	**344**

Table 3.3 Shows that the numbers of participants of each health facility/clinic were evenly distributed.

The following inclusion criteria were used:

- All women must be able to speak and understand Sesotho because there are many foreigners in the peri-urban and town setting.
- All women must have given birth outside health facility/clinic.
- All women are resident in Maseru Health Service Area.

- All women have attended a service provided at the health facility/clinic – consultation outpatient, antenatal care, postnatal care, child welfare and family planning.

■ Data level

A convenience sampling method was used to select the sample on data level, due to the fact that only those mothers who were willing to participate in the study were included. The mothers were attending a specific service on that day. The interviews were held by the researcher. The selection of the sample was done until the desired total of 344 was achieved.

3.3.3 Instrument used for data collection

Since the research design of the study was of a descriptive and exploratory nature, the instrument used for data collection was a semi structured interview, guided by an interview schedule. The interview schedule was compiled after a thorough literature review.

Simpson and Ormond (2000:58) and Polit & Hungler (1997:246) distinguish between three kinds of interviews as follows:

▪ *Structure Interviews*

McNiff (2001:73) states that structured interviews include strategies that provide increasing amounts of control by the researcher over the content of the interview. Questions asked by the interviewer are designed by the researcher prior to the initiation of data collection and the order of the questions is specified.

- ***Semi-structured interviews***

Semi-structured interviews are in between structured and unstructured interview. During a semi-structured interview the interviewer is generally required to ask a certain number of specific questions, but additional props are allowed or are encouraged. Both open-ended and closed ended questions are included in a semi-structured interview (White, 2002).

- ***In-depth interviews***

An in-depth interview according to McNiff (2001:73) refers to gathering information of a high quality or of a high degree to touch on personal feelings and emotions.

In this study semi-structured interviews were used to control the content due to the wide range of information and it is also time saving because you can direct the respondent's thinking to a specific topic and avoid wondering off (McMillan & Schumacher, 1997:447).

According to Bester (1998:68) and White (2002:48) the use of semi-structured interviews is formalized so that all respondents have the same question in the same order and in the same way. The semi-structured interview was to give guided responses to the topic.

Interview schedule

An interview schedule is a questionnaire with open-ended, closed-ended or fixed alternative questions.

The interview schedule must be presented to each respondent in exactly the same way to eliminate prejudice and to get homogenous response (Sotirios, 2000:48).

The interviewer is restricted to the questions, their wording and the order in which they appear on the schedule with relatively minimum/little freedom for deviation. This is done to minimize the role and influence of the interviewer and to enable a more objective comparison of results (White, 2002:66).

The structured schedule (see addendum F in English and G in Sesotho) was constructed after the literature review. The reason for this was that the information obtained from the reviewed literature clarified topics that were to be included in the interview schedule.

The interview schedule for this study included closed questions, open-ended questions and scaled items as follows:

- ***Closed questions***

These are short clearly stated questions with alternative responses. The alternative items allow the respondent to choose from two or more alternatives. The most frequently used is the dichotomous item which offers two alternatives only – Yes/No. sometimes a third alternative such as don't know is offered (Simpson & Ormond, 2000:59). In this study closed questions were used to limit the minimum chances for irrelevant answers, because of the clearer meaning of the questions and to allow them to answer directly e.g. Are you married? Yes/No

Advantages

- The answers are standard and can be compared from person to person.

- Qualification and analysis of results may be carried out easily and effectively.
- The respondent is often clearer about the meaning of the question. (Leedy and Ormrod (B) 2005)

Disadvantages

- Responses give a narrow meaning.
- It is easy for the respondent who does not know the answer to choose the don't know categories.
- The respondent may feel frustrated because the appropriate category for her answer is not provided.
- There are greater chances for clerical error as the respondent may circle one answer when she meant to circle the other answer. (Leedy and Ormrod (B) 2005

- ***Open-ended questions***

Open ended questions are used for complex questions that cannot be answered in a few simple categories, but require more detail discussion. The respondent makes any response she wishes in her own words. Open questions were used in this study to give the respondents an opportunity to express their feelings, opinions, emotions as well as expanding on ideas about having births outside a health facility (Sarantakos, 1997:69 – 71; White, 2002:70). Open ended questions were included for sensitive issues that needed more clarity.

Advantages

- Open-ended questions can be used to explore experiences of respondents.

- They allow more opportunity for creativity or self expression by the respondent.
- They allow the respondent to answer adequately in all the detail she likes to qualify and clarify her answer.

Disadvantages

- It may lead to the collection of worthless and irrelevant information.
- Open-ended questions require respondents to think deeply. (Leedy and Ormrod (B) 2005)

- ***Scaled items***

A scaled response is one structured by means of a series of gradations. The respondent is required to record her response to a given statement by selecting from a number of alternatives.

Example: your earnings enable you to meet your needs?

Fully	☐
Partially	☐
Not at all	☐
Not sure	☐

Scaled items are used when persons or events or other phenomena are named or categorised into mutually exclusive categories. Even feelings can be classified using scales e.g. happy, unhappy, indifferent; thus enabling the comparison between degrees of happiness of different persons (Brink, 1996:147; White, 2002:69). In this study scaled items were used because it was the preferred method for clarity on responses given.

Advantages

- Scaled items can be easily developed.

Disadvantages

- Scale items force respondents to make a choice.
- Scaled items are likely not to be responded to.

Simpson & Ormond (2000:69) further state that the interview schedule has other types of items that usually consist of two parts:

- A biographical part where respondents respond to questions regarding personal issues which are of importance to the research.
- The main part where respondents respond to questions/statements directed at the issues being investigated.

■ Instrument validity

Validity refers to the ability of an instrument to measure the variable that it is intended to measure (White, 2002:148). Validity of the instrument was increased by:

➢ The literature review that clarified topics to be included in the interview schedule (Burns & Grove, 2001:109) and (De Vos & Fouche, 2000:98).

➢ Domain experts in the University of the Free State and in Lesotho evaluated the interview schedule regarding content validity, the logical sequential flow of questions and the wording (University of the Free State Ethics Committee, 2005; Ministry of Health & Social Welfare, 2005).

- A Pilot study was conducted in one health facility/clinic in Maseru Health Service Area with 4 women conveniently sampled. The purpose of this pilot study was to test the interview schedule for its clarity as well as areas that need modification as well as give the researcher experience in the use of the schedule. There were no changes made to the interview schedule after the pilot study (Burns & Grove, 2001:40).

- The interview schedule for this study was constructed in English and then translated into Sesotho which is the local language spoken by most women in Lesotho. This was also done to ensure that meanings of the questions remained the same.

In this study validity regarding construct, content and face validity of the instrument was also addressed as follows:

- ***Construct validity***

Construct validity was enhanced by personalizing questions regarding emotions e.g. how did you feel about the support (Burns & Grove, 2001:222). Construct validity is useful mainly for the measures of traits or feelings such as generosity, anxiety, grief and happiness. Because respondents answered questions in their own language (Sesotho) construct validity was assured.

- ***Content validity***

Bens & Higson-Smith (1999:140) refer to content validity as an assessment of how well the instrument represents all the different components of the variables to be measured. Content validity is used namely in the development of questionnaires, interview-schedules or interview guides. In this study relevant

literature was reviewed and such a review revealed the essential aspects of the variables that must be included in the content. Open-ended questions were asked to overcome a sit response because respondents had to motivate their answers.

- ***Face validity***

According to White (2002:145) face validity is the most obvious kind of instrument validity. It is based on an intuitive judgement of experts in the field. In this study face validity was done by domain experts in the University of the Free State (Expert Committee and Ethics Committee) as well as experts in the Ministry of Health and Social Welfare in Lesotho. These domain experts evaluated the instrument to see if the questions were valid.

■ Instrument reliability

According to White (2002:140) reliability of the instrument refers to the degree to which the instrument can be depended upon to yield consistent results if used repeatedly over time on the same persons, or if used by two different investigators. The reliability of an instrument is indicated by a correlation measure which varies.

In this study reliability was assured by conducting a pilot study.

■ Pilot study

According to Brink (1996:173); Burns & Grove (2001:49 – 50) and Leedy & Ormrod (2005:110), a pilot study is commonly defined as a smaller version of a proposed study. A pilot study was conducted in one of the nine clinics. Four women who met the inclusion criteria were respondents to the interview

schedule. However, the one clinic and four women were not part of the main study. The respondents did not have any difficulty in responding to any of the questions on the interview schedule. The researcher analysed collected data manually. The results of the pilot study did not contribute to making any changes on the interview schedule. However, the researcher gained experience in the use of the interview schedule, was made familiar with respondents and the way they respond to the questions. The length of time the interviews took was also recorded 50 – 55 minutes. The results of the pilot study did not raise a need for any refinement or modification on the interview schedule. The respondents were able to answer all of the questions on the schedule. The results of the pilot study did not form part of the main study.

3.4 RESEARCH PROCESS

According to Burns & Grove (2001:40) the data collection process consists of the following steps, entering into the field, the data gathering process and leaving the field. These steps will be discussed as follows:

3.4.1 Entry into the field

To gain entry into the field written permission was granted by the Ethics Committee of the Faculty of Health Sciences at the University of the Free State (see Addendum A) as well as from the Ministry of Health and Social Welfare and Private Health Association of Lesotho (see Addendum B and C). Nurse Managers at the health facilities also granted approval for the identification of mothers who meet the sampling criteria and to also explain the purpose of the study to them. Consent from parents/guardians of all subjects who were under 18 years (as they are under age) as well as from the participants themselves was also obtained (see Addendum D and E).

3.4.2 Collection of data

Data collection according to Burns & Grove (2001:461) is involved in interrelated tasks that occur concurrently, that is identifying the right subject, collecting data in a consistent way, maintaining research controls as indicated in the study design and solving problems that threatened to disrupt the study.

In this study semi-structured interviews were conducted and respondents were requested to respond to questions outlined in the interview schedule. For the interview to be successful it is important for the researcher to gain cooperation from the respondents.

■ Establishing researcher's role

In an effort to establish good relationship and to gain cooperation of the participants the following was done:

- The researcher was wearing nurse's uniform on the interview days and arrived at the health facility 30 minutes earlier before starting interviews. This time allowed the researcher to be familiar with the interview room, arrange interview schedules and consent forms on the table as well as the waiting hall where the mothers would be seated.

- The purpose of the study was explained to the participants as well as the fact that the data is confidential. The purpose of the study was explained as to describe births outside a health facility as a phenomenon. All data is confidential because the subjects are only known by the researcher.

- Create a comfortable non threatening environment.

The interview room was clean, well ventilated as it was very hot, with two chairs that were comfortable, some flowers on top of the filling cabinet and that made the room look bright and homely. There was no disturbance any other traffic or around except for the researcher and the waiting mothers. In all health facilities the interviews were conducted in the office of the nurse in charge or in a consulting room.

- ***Collection of data***

The researcher had arranged prior with the nurse in charge to identify the mothers for the study. The identified mothers for the study were seated in the waiting hall, which was not far from the interview room. The nurse in charge showed the researcher the identified mothers who met the criteria for the study. The researcher was introduced to the participants by the nurse in charge.

The researcher entered the interview room and asked the first mother to enter and sit on the chair. The researcher gave the mother the consent form after explaining that the consent form contained information about the study and requests for permission to participate. The mothers read through the consent form and lastly signed – thus granting permission to participate. Having gone through this step, the researcher asked once more if there were any questions. If no questions the researcher thanked the mothers. There were a few parents/guardians who were hesitant to give permission for their under 18 year's daughters to be interviewed. The reasons given were that their daughters would be embarrassed, they are shy and they would not talk freely. Further explanation about anonymity, confidentiality and overall importance of the study helped to resolve the problem.

The mothers were interviewed one by one until all these mothers were interviewed.

Conducting the semi-structured interview the following aspects were addressed:

- Providing privacy by using a room exclusively for the interview.
- Starting with non threatening information to set participants at ease, like how old are you followed by more personal and sensitive questions.
- Making eye contact to make listening more effective is culturally acceptable.
- Asking permission to write down what is said.
- Clarify and check perceptions by giving a summary of the basic response after each question.
- Asking clarifying questions or asking respondent to elaborate to gain more information.
- Interpreting the meaning of the question if the respondent does not understand.
- Interview was done in Sesotho because most mothers speak Sesotho and could express themselves better.
- After the interview the researcher thanked each person for their participation.

After everybody was satisfied that the topic was exhausted the researcher left gracefully the field by thanking each mother for her willingness to participate in the study.

3.4.3 Leaving the field

Leaving the field according to Burns & Grove (2001) and White (2002) is the last step in data collection. The researcher thanked all nurse managers of the health facilities/clinics for their outstanding support and willingness to identify mothers who met the study criteria, as well as making the necessary preparations in the

health facilities/clinics for the smooth running of the interviews. A preparation such as a private interview room, away from noise was appreciated. Parents/guardians of under 18 year's participants were also thanked for their support by the researcher. The researcher also thanked the mothers and assured them that nobody will know who said what and who the respondents were as there are no names written on the interview schedule.

3.5 ANALYSIS OF DATA

The purpose of data analysis according to White (2002:82) is to process the data in an organized way so that the data is displayed in a systematic way as well as to establish the composition of the biographic data of respondents.

Analysis of the content of the interview schedule establishing the reasons for birth outside health facility, the place of birth, who the helper/attendant was, the experiences of mothers during birth, the outcomes of birth and the cultural practices adhered to during birth was done.

In an effort to address the aims of data analysis the following was done:

- After a literature study the interview schedule was compiled.
- A pilot study was done to ensure validity and reliability of the interview schedule.
- Closed-ended questions obtained through the interview schedule were analyzed by the Biostatistics Department of the University of the Free State. Frequencies and percentages for categorical data and medians and percentiles for continuous data was collected.
- Duplicates were made for the analysis of the open-ended questions by an independent nurse experienced in phenomenological research analysis.
- Reduction of the data was done by organizing and categorizing the data of the open-ended questions.

- Open-ended questions were analyzed using the method described by Tesch (in Creswell, 1994:144 – 155).

The analysis of open-ended questions was done by the researcher and an expert coder according to Tesch method as follows:

1. Get a sense of the whole, by reading through all of the questions (narrative) carefully. Perhaps jot down some ideas as they come to mind.

2. Pick one document (one narrative) – the shortest one on top of the pile. Go through it, asking yourself what is it about? Do not think about the "substance" of the information, but rather its underlying meaning. Write thoughts in the margin.

3. When you have completed this task for several informants, make a list of all topics. Cluster together similar topics. Form these topics into columns that might be arrayed as major topics, unique topics and leftovers.

4. Now take this list and go back to your data. Abbreviate the topics as codes and write the codes next to the appropriate segment of the text. Try out this preliminary organizing scheme to see whether new categories and codes emerge.

5. Find the most descriptive wording for your topic and turn them into categories by grouping topics that relate to each other under a specific category. Perhaps draw lines between categories to show interrelationships.

6. Make a full decision on the abbreviation for each category and these codes.

7. Assemble the data material belonging to each category in one place and perform a preliminary analysis (Tesch in Creswell, 1994:155).

8. The main coder and the researcher worked independently. Thereafter they discussed and compared their findings. After consensus was reached, the final coding was accepted and all the data was analysed according to the final system.

This method scrutinizes the data obtained from emergence of themes, sub themes with the aim of capturing the "essence" of the information being studied by identifying its constituent parts (Tesch in Creswell, 1994:144 – 155).

The open-ended questions were analysed according to Tesch's method and according to Babbie and Mouton (2000:277) aspects like trustworthiness, creditability and confirmability are applicable to this type of analysis.

- **Trustworthiness**

The researcher was neutral and objective and had no preconceived ideas regarding births outside health facilities.

Objectivity was obtained by getting the trust and support of the participants before hand, conducting the interview in a respectful way in a private place.

- **Credibility**

A pilot study was done to evaluate the questions for the interview schedule. The researcher validated her summaries of the interview by reading it back to the participants to ensure if it was what they have said.

- **Confirmability**

Is the extend that the data from the interview corresponds with the phenomenon under study. The summaries, interpretations and recommendations were given to an independent person for confirmation.

■ Validity and reliability of the study

According to Burns and Grove (2001:226) study validity refers to a measure of the truth or accuracy of a claim, an important concern throughout the research process. Reliability represents the consistency of the measure obtained. Validity and reliability of the study were endorsed by:

- Establishing a trusty relationship between the mother and the researcher before the interview.

- Informing participants beforehand about the aim of the study to increase their participation.

- Taking into account the cultural background of the participants by doing the interview in Sesotho. This maintained consistency and also allowed respondents to verbalise their views in their own language.

- Including open-ended questions in the schedule to motivate and elaborate on answers.

- Domain experts on the subject under study, which is birth outside health facility, reviewed the study proposal and interview schedule. These domain experts provided inputs, comments which substantiated the study. The related and relevant literature to the study provided a guide to the

development of the interview schedule and shared experience on the topic in other countries by different authors (Burns & Grove, 2001:226).

- A pilot study conducted determined the feasibility of the study, examined the validity and reliability of the research instrument identifying any problem in the research process (Burns & Grove, 2001:40). Data collection was done by the researcher using the Sesotho version of the interview schedule.

In an effort to increase the validity and reliability of the study, triangulation was build into the study (Simpson & Ormond, 2000:290; and Burns & Grove, 2001:243).

■ Data triangulation

Burns and Grove (2001:231) states that data triangulation refers to the collection of data from multiple sources, with similar focal points to obtain diverse views. In this study data was obtained from mothers who gave birth outside health facilities in the Maseru Health Service Area, whether from town, peri-urban or rural settings.

■ Theoretical triangulation

Theoretical triangulation as stated by Burns and Grove (2001:240) is the use of all theoretical interpretations that could conceivably be applied to a given area as a framework for the study. To ensure theoretical triangulation in this study, literature review of books, journals, articles was done.

3.6 ETHICAL CONSIDERATION

Conducting nursing research requires not only expertise and diligence but also honesty and integrity (Burns & Grove, 2001:206) as well as protection of the human rights of respondents as described in the ethical standards of nurse researcher principles of the Democratic Nurses Association of South Africa (DENOSA) (1998:1 – 7). Research ethics is reflected on table 3.4.

Table 3.4: Research ethics

Ethic rule	Application
Planning	The research planned thoroughly as described in the methodology
Implementation	The researcher compiled a usable report at the end of the study by use of guidelines.
Integrity	The researcher took into consideration all ethical aspects according to Burns and Grove (1997:94) and approached the study with integrity. (DENOSA
Honesty	All aspects promised to respondents were fulfilled e.g. confidentiality and data analysis was done with honesty.
All findings	All findings were used in the research
All participants must be acknowledged	All participants were acknowledged after consenting to participate.

The following ethical actions were adhered to in this study:

■ Protection of human rights

The human rights that required protection in this study included the following:

(i) The right to self determination

The prospective respondents were treated as autonomous agents by being informed about the nature of the proposed study and allowing them to voluntarily choose to participate or not to participate, as well as to withdraw from the study at any time without any penalty.

(ii) The right to privacy, anonymity and confidentiality

Informing them that data collection would not be made accessible to people other than those involved in the research protected the respondent's privacy. In addition, respondents were assured that their identity would not be linked with their responses by the researcher.

(iii) Obtaining informed consent

Before starting the interview the researcher asked the mothers to read through the consent form and sign. A written permission to participate in the study was obtained from the participants as well as from the parents/guardians of the adolescents younger than 18 years following explanations regarding the purpose of the study, method of obtaining information and how information would be used. Furthermore the consent form was provided with instructions assuring anonymity and voluntary participation.

(iv) Permission granted by the necessary institutions/persons

The research protocol was submitted to both the experts and Ethics committee of the Faculty of Health Sciences of the Free State as well as to the Ministry of Health and Social Welfare and Private Health Association of Lesotho so as to obtain permission prior to the data collection process.

■ Permission to enter the field

The Ethics Committee of the University of the Free State reviewed the protocol for the study thus assuring that it was properly done. The Ministry of Health and Private Health Association of Lesotho granted permission to enter the field.

3.7 PROBLEMS ENCOUNTERED

During the conduct of the semi-structured interviews the following problems were encountered:

- The first interviews were long but as the researcher became more familiar with the schedule the interview became shorter. The effect of this was that some participants withdrew as they did not want to wait that long.

- Reluctance to discuss the reasons why they gave birth outside the health facility made it necessary for the researcher to explore the open-ended questions in greater depth and that made the interview much longer.

- Some parents/guardians were hesitant to give permission for their under 18 year's adolescents to be interviewed.

3.8 VALUE OF THE STUDY

The results of the study will provide additional information necessary to plan the nursing interventions in an effort to enhance safe motherhood in Lesotho. Findings will be made known to the Ministry of Health and Social Welfare and Christian Health Association of Lesotho. A journal article will add value to this study because the results of the study will not only benefit Lesotho but may also benefit other African countries with similar problems of births outside health facilities.

3.9 SUMMARY

A complete discussion of the research methodology was done in this chapter. During this discussion the requirements of a descriptive non-experimental research process were addressed in an effort to ensure the validity and reliability of the study. The results of the data analysis process will be discussed in Chapter 4.

CHAPTER 4

EXPLANATION OF THE RESULTS OF THE STUDY

4.1 INTRODUCTION

Data analysis entails categorizing and summarizing data and describing it in meaningful terms (White, 2005:48). Data analysis involves three activities namely: data reduction, categorization and interpretation. The aim of these intertwining actions is to clarify the research question.

4.2 THE REDUCTION AND CATEGORISATION OF DATA

Reduction is the process of selecting, focusing, simplifying and transforming of the data in the transcriptions (White, 2005:84) therefore, because of the volume of data acquired in a non-experimental design of a descriptive nature, initial efforts of analysis focused on reducing the data to facilitate the analysis process. During the data reduction phase, the data obtained from all open-ended questions in the semi-structured interview schedule was reduced and analysed according to the steps described by Tesch (in Creswell, 1994:145 – 155). Data was evaluated by an independent coder who picked one document on the top and read through it not bothering about the substance. Thereafter she clustered together similar topics and organized it into schemes, grouped topics into categories and drew lines to show interrelationships.

The statistical analysis of the closed-ended questions was done by the Biostatistics Department of the University of the Free State. Frequencies and percentages for categories for categorical data and medians and percentiles for continuous data was collected.

4.3 EXPLANATION OF DATA OBTAINED FROM THE INTERVIEW SCHEDULE

The results obtained from the data analysis will be discussed as follows:

- Section A : Demographic data of the mother
- Section B: Data which shows the place of birth of babies, the reasons for birthing outside health facility, who the helper was during birth, the outcomes of births, the experiences of the mothers and the cultural practices involved during birth.

SECTION A

4.3.1 The demographic data obtained

The demographical data will be discussed as follows: geographical location of health service and place of residence of the mother.

4.3.1.1 Distribution of respondents by health facility and place of residence

The distribution of respondents by health facility and place of residence is reflected on table 4.1

Table 4.1: Distribution of respondents obtained from health facilities and place of residence

Health facility	Number of participants	Percentage %
Queen Elizabeth II Clinic	43	12.50
Qoaling Filter Clinic	43	12.50
Mafukeng	43	12.50
Makoanyane	43	12.50
Bethany Clinic	42	12.21
Holy family	42	12.21
Khubetsoana	43	12.50
Good Shepherd Clinic	45	13.08
Place of residence		
Town	44	12.8
Peri-urban	130	38.8
Rural	170	49.4

The results in table 4.1 reveal that health facilities had adequate respondents for the study and most women resided in the rural area (49%).

4.3.1.2 Respondents age In years, marital status, number of children per women, birth order of children born outside health facility

Respondents age in years, marital status, number of children per woman, birth order of children born outside health facility are reflected on table 4.2.

Table 4.2: Respondents age in years, marital status, number of children per woman, birth order of children born outside health facility

	Total = No 344	100%
Age in years	**Number of participants**	**Percentage %**
> 18 year	49	14.3
19 - 24	149	43.3
25 – 39	97	28.2
40 – 59	49	14.3
Marital status		
Married	238	59.10
Single	87	25.36
Widow	19	5.54
Number of children		
1	144	41.6
2	77	22.4
3	38	11.0
4	29	8.4
5	22	6.4
6	20	5.8
7	6	1.7
8	6	1.7
9	2	0.6
Birth order of each child		
First	153	43.31
Second	76	20.93
Third	43	11.34
Fourth	34	8.43
Fifth	26	6.10
Sixth	25	5.81
Seventh	10	1.74
Eighth	10	1.74
Nineth	4	0.58

Birth order of babies born outside health facility	Number of participants	Percentage %
1	235	69.0
2	33	31.0
3	31	9.0
4	31	9.0
5	26	6.7
6	17	5.8
7	14	3.2
8	6	0.6
9	4	0.3

Table 4.2 Reveals that the women were mostly young (aged 19 – 24) 43% with 14% of teenagers. The youngest women aged 15 years constituted 0.9% and the oldest women aged 50 years constituted 0.6% and the median age was 23. The majority of women were married 59%. Women who had one child were 43%. The birth order for 43% of the children were the first child and 68% of the children were born outside health facility.

4.3.1.3 Religious denomination of women, their level of education, employment status, ability of earnings to meet their needs, financial support received and source of support

Religious denomination of women, their level of education, employment status, ability of their earnings to meet their needs, financial support revealed and from whom is reflected on table 4.3.

Table 4.3: Religious denomination of women, their level of education, employment status, ability of their earnings to meet their needs, financial support received and source of support

	Total = No 344	100%
Religious denomination	**Number of participants**	**Percentage %**
Roman Catholic	140	41.06
Lesotho Evangelical Church	88	25.81
Anglican	60	17.60
Methodist	22	6.65
Seventh Adventist	10	2.93
Others (Zion, Watchtower)	21	6.16
Level of education		
Primary	101	29.53
High school	214	53.57
Tertiary	29	7.89
Employment status		
Employed	48	13.70
Unemployed	296	85.30
Ability of earnings to meet needs		
Fully	18	40.96
Partially	24	54.58
Not met	2	4.55
Financial support received		
Yes	296	100
Source of support		
Husband	151	66.52
Parents (mother/father)	56	25.22
Brother/sister	3	1.30
Social welfare	4	1.74
Husbands sister	3	1.30
Boyfriend	2	0.87
Church small jobs	2	0.87
Uncle	2	0.87
Grand mother	2	0.87

Table 4.3 reveals that most women (59%) belonged to the protestant and other Christian churches. Most women (90%) were literate, unemployed (85%) however 55% could partially meet their needs. All the women who received financial support (100%) were supported by their husbands (67%).

SECTION B

4.3.2 Health providers discussions with women on available services during birth while visiting at health facility

The health providers discussions with women on available services during birth reflected on figure 4.1.

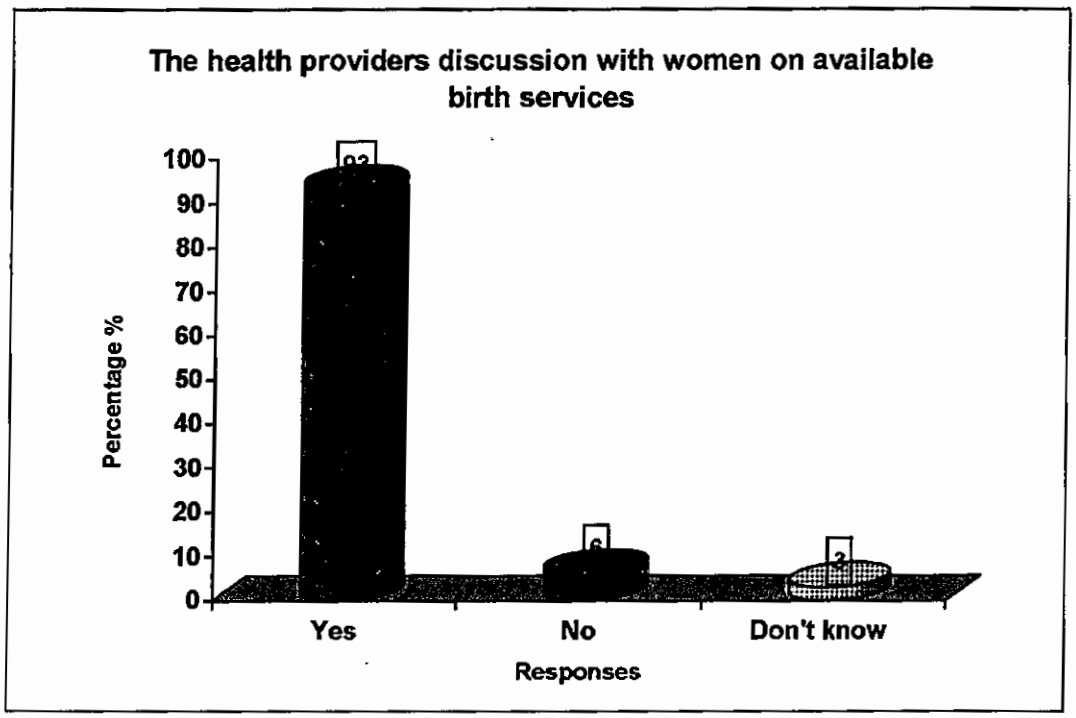


Figure 4.1: Health providers discussions with women on available services during birth

Results on figure 4.1 reveal that almost all women (93%) received information on available birth services.

4.3.2.1 Types of birth

Types of birth discussed to women is reflected on table 4.4.

Table 4.4: Types of birth discussed to women

Topics	Number of participants	Percentage %
Normal birth	313	100
Birth by forceps	268	85.5
Caesarian section	293	93.6

Table 4.4 Reveals that although normal birth was discussed with all women, 100% abnormal births was also discussed with most of the women.

4.3.2.2 Place of birth and reasons why babies were born outside health facility

Place of birth and reasons why babies were born outside health facility is reflected on table 4.5.

Table 4.5: Place of birth and reasons why babies were born outside health facility

Had baby at home	Frequency	Percentage %	Main theme	Sub theme	Explanation (reasons)
Yes	341	99.42	Intentional	At home	• Wanted to squard during process of birth. • There was no money for hospital/health facility fees. • Hospital health facility too far. • Not treated well last time. • There was no transport. • Comfortable with home birth. • Liked family warmth and attention given. • There was no nurse at health facility after hours • Health facility gate locked after hours. • Not trusting health facility. • I feel comfortable at home and there is safety. • Health facility uses dirty linen. • Nurses were rude last time. • Wanted to promote my culture. • I was alone.
No	2	0.58	Unintentionally	On the way in public transport	• Baby came too fast. • Baby came early 7/12 8/12

Table 4.5 reveals that most babies were born at home. The place of birth was planned during pregnancy.

4.3.2.3 Reasons for not going to a health facility for birth

The reasons why mothers gave birth outside health facilities is reflected on table 4.6.

Table 4.6: Reasons for not going to a health facility

Responses	Frequency	Percentage %
Health facility too far	135	39.24
Had no money	76	22.09
Baby came too fast	210	61.05
Not treated well last time	73	21.22
Others (no transport)	231	67.15

Table 4.6 reveals that most women 67% were unable to go to the health facility because there was no transport. Nearly a quarter of the women did not go to the health facility because they were treated badly previously. More than one response was given to every question.

4.3.2.4 Persons who advised women to give birth outside health facility

Persons who advised women to give birth outside health facility are reflected on table 4.7.

Table 4.7: Persons who advised women to give birth outside health facility

Persons	Frequency	Percentage %
Parents	159	46.22
Peers	3	0.87
Husband	83	24.13
Boyfriend	-	-
Nurses	1	0.29
Self	308	89.53
Others	112	32.56

Table 4.7 shows that although most women (90%) made their own choice to give birth outside health facility. Elders (46%) still have a big influence upon their decision on where to give birth.

4.3.2.5 Those who assisted women during labour and reasons why they had to assist

Those who assisted women during labour and the reasons why they had to assist are reflected on table 4.8

Table 4.8: Those who assisted women during labour and the reasons why they had to assist

Support person	Total = No 344		
Mothers assisted	**Number of participants**	**Percentage %**	**Reasons why they had to assist or did not assist**
Yes	161	46.80	• Mother has assisted other family members previously, without any complications, she has experience. • She was the only person around me. She had to assist, there was no choice. • She assists birth for free with no payment. • Mother does good job during birth with no tears and no complications. • Mother is an experienced retired midwife.
No	183	53.20	• Mother died. • Mother at work. • Mother is afraid of assisting during birth. • Mother is ill. • Mother too old to assist. • Mother works away from home (Republic of South Africa). • Mother not staying here now, with another family. • Mother away attending a funeral.
Friend assisted			
Yes	1	0.30	• She was the only person with me then.
No	343	99.70	

Traditional birth attendant assisted	**Number of participants**	**Percentage %**	**Reasons why they had to assist**
Yes	16	4.66	• She visited me at the time of birth. • She is near my house. • She has assisted me previously.
No	328	95.34	
Neighbour assisted			
Yes	12	3.53	• She has always assisted her own children well. • She is near to me and assists me well too.
No	332	96.47	
Traditional healer assisted			
Yes	3	0.90	• She assisted me well previously. • She stays near to my house.
No	222	99.10	
Others who assisted	**Sub-themes**	**Percentage %**	**Reasons why they assisted**
Family members	Grand mother	48.68	• She was the only person around with me, had to assist. • As family member with experience in assisting during birth, she assisted very well, capably. • Sister had birth apprenticeship training. • Had assisted self with previous births no problem. • She was alone; she had to assist herself/no choice.
	Aunt	19.74	
	Sister	11.84	
	Mother-in-law	4.69	

Others who assisted	Sub-theme	Percentage %	
Self	Self assisted	13.82	• I was alone in the house.
House keeping lady		1.66	• She was the only person with me.

Table 4.8 shows that most mothers were supported by their family members, mostly grandmothers (49%) and their mothers (47%) and 5% of mothers were supported by the traditional system.

4.3.2.6 Time of arrival at the scene of birth by the assistant

Responses given as to when the assistant arrived at the scene of birth are reflected on table 4.9.

Table 4.9: Time given as to when the assistant arrived at the scene of birth

Time of arrival at scene of birth	Frequency	Percentage %
Before the time	299	96.76.
When contractions started		
When the head was out	10	3.74
After the birth of the baby		

Table 4.9 reveals that most of the assistants (97%) arrived before the time of birth.

4.3.2.7 Arrangements made for somebody to assist during birth

Arrangements made for somebody to assist during birth is reflected on figure 4.2

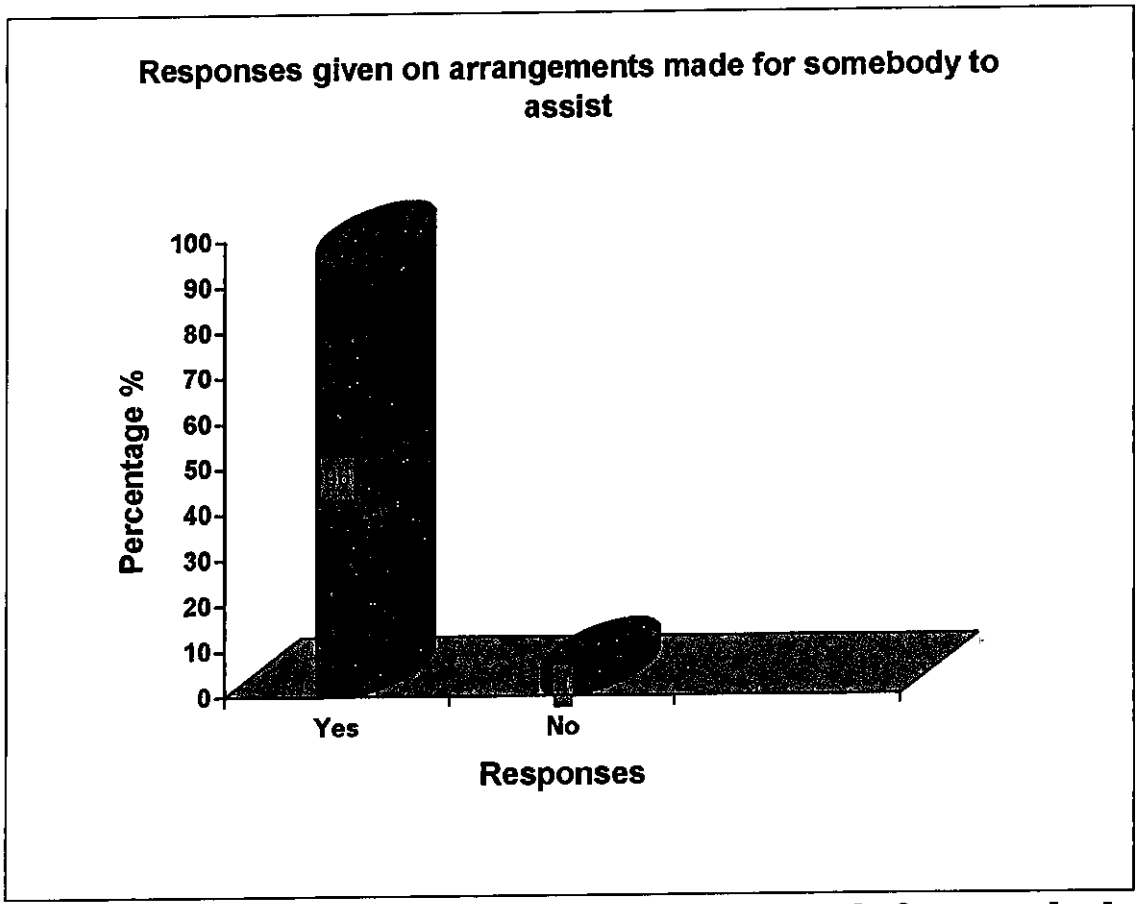


Figure 4.2: Responses given on arrangements made for somebody to assist during birth, and whether this person was on time

Figure 4.2 reveals that most women (96%) arranged for somebody to assist during birth.

4.3.2.8 Presentation of the fetus

Presentation of the fetus as indicated by the mother as "the part of the baby that came out first" is reflected on figure 4.3.

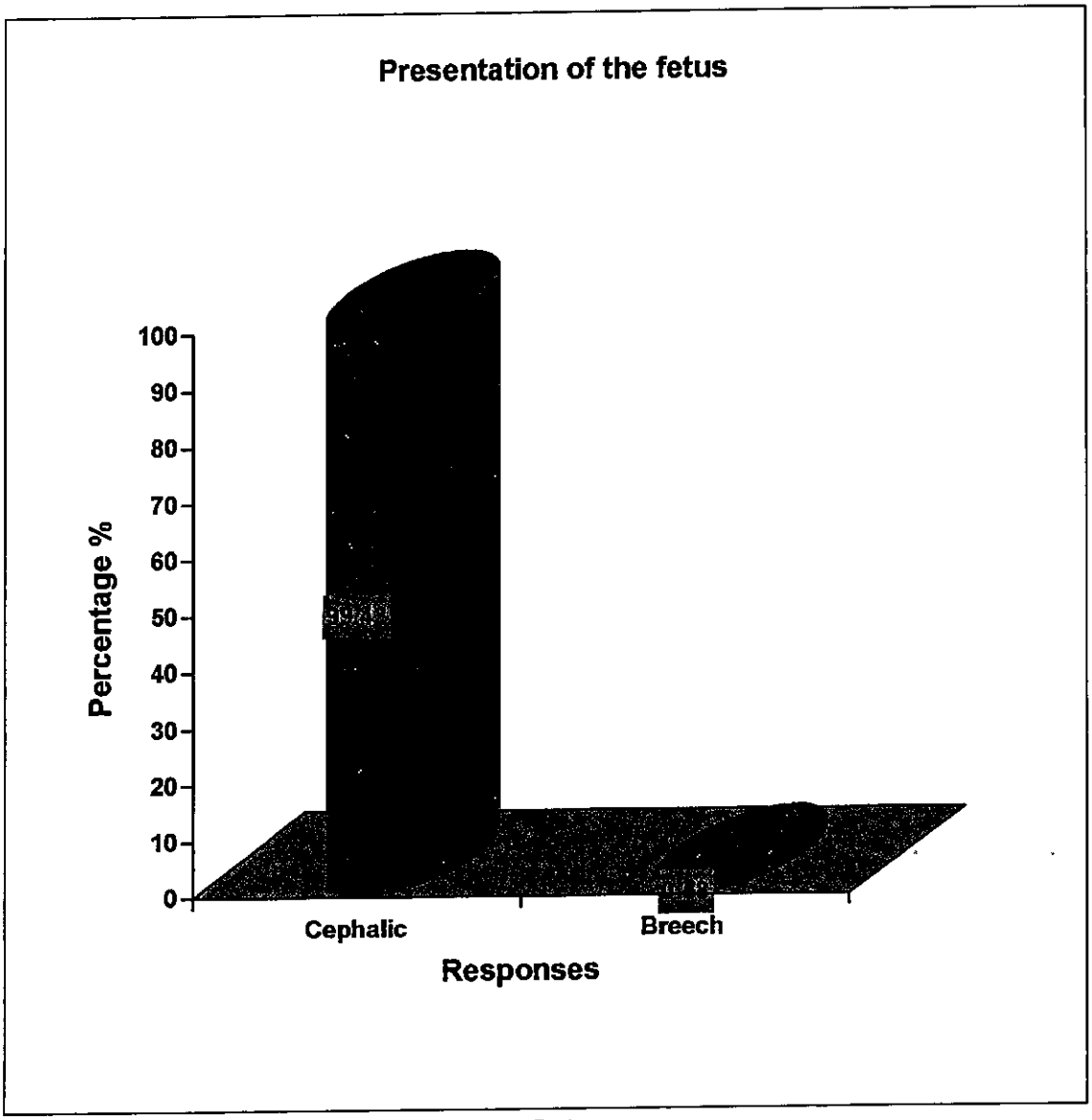


Figure 4.3: Presentation of the fetus

Figure 4.3 shows that most babies (99,42%) were born cephalic and the rest were breech.

4.3.2.9 Persons asked to assist mother during birth

Responses made on the person asked to assist mother during birth is reflected on table 4.10.

Table 4.10: Responses made on the person asked to assist mother during birth

Persons who assisted mother during birth	Number of participants	Percentage %
Mother	159	52.30%
Grandmother	68	22.37%
Aunt	29	9.54%
Sister	18	5.92
Traditional birth attendant	14	4.61
Neighbour	8	2.63
Mother-in-law	7	2.30
Traditional healer	1	0.33

Table 4.10 shows that mothers (52%) had arranged with her own mother to assist during birth.

4.3.2.10 Second and third stage of labour

Second and third stage of labour is reflected on table 4.11

Table 4.11: Second and third stage of labour

Type of birth	Number	Percentage %	Explanation
Normal	341	99.13	• Cephalic
Abnormal	2	0.87	• Breech
Condition of baby			
Alive	344	100	• Cried immediately
Cried spontaneously	326	95.32	• After unveiling face and head and cleaning the mouth • The head and body were born when baby cried.
No cry	18	4.68	• Need stimulant to cry
Cord prolapse	2	0.58	• Cord came out first
Blood loss			
Little blood lost	329	05.64	• One scooped hand full of blood
Too much blood lost	75	4.66	• More than one scooped hand full of blood
Delivery of placenta			
Immediately	327	95.34	• Spontaneously delivered
Delayed	16	4.66	• Delivered by hand

Time placenta delivered	Number	Percentage %	Explanation
30 minutes after birth	4	22.67	• Delivered by hand
1 hour after birth	10	66.67	• Delivered by hand
2 hours after birth	2	10.67	• Delivered by hand
Disposal of placenta	344	100	• Buried by helper • Buried by mother • Buried by family elder
Perineal tears			
Yes	130	37.79	• Tear on perineum
No	214	62.21	
Place where perineum was sutured			
Hospital	39	58.21	• Sutured by doctors, nurses/midwife
Health centre	27	40.30	• Sutured by nurse/midwife
Home	1	1.49	• Sutured by retired midwife at home

Table 4.11 reveals that all babies were born alive (100%) with a loud cry and 2 babies (0.58%) with cord prolapse were stimulated to cry and they survived. Most babies had a normal vaginal birth (99%) and most mothers had little bleeding (96%). The placenta was delivered immediately (95%) and spontaneously for (99%) of mothers while two placentae were removed by hand. At the most the placenta took 1 hour to deliver (67%) after birth and it was buried by the mother (62%). The majority of mothers did not have a perineal tear (67%) and for those who had a tear, they went to a health facility for suturing, while 1 tear was sutured at home by a retired midwife.

4.3.2.11 Immediate care of the baby

The immediate care of the baby is reflected on table 4.12

Table 4.12: Immediate care of the baby

	Total = No 344	
Helper cleans baby's mouth	**Frequency**	**Percentage %**
Yes	343	99.42
No	1	0.58
How baby's mouth was cleaned		
Helpers mouth	89	25.95
Helpers fingers	241	70.25
Cloth	10	2.93
Don't know	3	0.87
Helper clamp cord		
Yes	344	100
What was used to clamp cord		
Twine	171	49.7
Woven cotton	172	50.0
Shoe lace	1	0.29
Helper cut cord		
Yes	344	100
What was used to cut cord		
Scissors	130	37.79
New razor blade	145	42.44
Reed	68	19.77
Treatment of cord		
Cow dung		
Sand	5	1.46
Ash	64	18.66
Nothing	213	62.10
Others (dettol water, granite stone)	15	18.00

Helper wipe baby dry	Frequency	Percentage %
Yes	343	99.71
No	1	0.29
Baby is wrapped warm		
Yes	343	99.71
No	1	0.29
What kept baby warm		
Baby wrapper	343	99.71
Mothers blanket	235	68.51
Mothers abdomen	149	43.44
Others (shawl, duvet, sheep skin)	41	11.95
Place where baby was kept after birth		
With mother	343	99.71
Away from mother was with grand mother	1	0.29
First fluid given to baby		
Clean water	17	4.96
Water with sugar	19	48.00
Breast milk	248	78.08
Others (wheat porridge)	2	0.58
Baby's first suck from breast		
Immediately	201	59.36
After one hour	100	31.10
After three hours	34	9.58

Table 4.12 reveals that mostly baby's mouth was cleaned (99%) using helpers finger (70%). All cords were clamped for babies (100%) using cotton (50%) and all cords were cut (100%) using a new razor blade (42%). There was nothing (62%) applied on the cord and babies were wiped dry (100%) as well as wrapped warm and kept warm. Mostly the babies were kept with their mothers (100%) given breast milk (78%) as first fluid immediately (59%) after birth. More than one response would be chosen by respondents for keeping baby warm.

4.3.2.12 Care of mother after birth

Responses given for care of mother after birth are reflected on table 4.13:

Table 4.13: Care of mother after birth

Responses given for care of mother	Number of participants	Percentage %
• Had a bath	342	99.42%
• Given food to eat	341	99.15%
• Made to sleep comfortably	340	98.84%
• Went to health facility	68	19.97%
• Walked home	6	1.74%
• Went to grand mothers place	3	0.87%

Table 4.13 shows that most mothers (99%) had a bath and were given food to eat (99%). More than one response would be chosen by the respondents.

4.3.2.13 The protective measures used by helpers during birth

Protective measures used by helpers during birth are reflected on table 4.14.

Table 4.14: Protective measures used by helpers during birth

Protective clothing used	Number of participants	Percentage %
• Gloves	246	73.48
• Plastic bags for gloves	73	21.22
• Plastic apron	25	5.3

Table 4.14 shows that gloves were mostly used (73%) as protective clothing during birth.

4.3.2.14 The mothers experience of this birth process

The mother's experience of this birth process is reflected on figure 4.4.

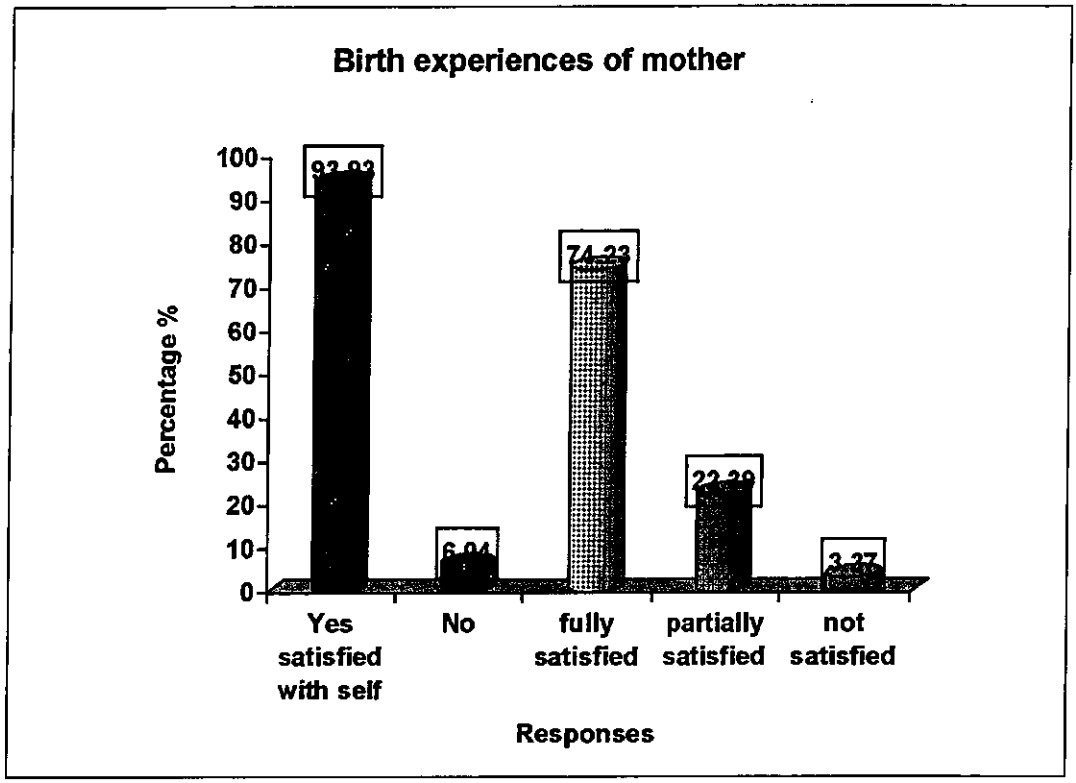


Figure 4.4: Birth experiences of mother

Figure 4.4 shows that mothers were mostly satisfied with themselves (94%) and fully satisfied with the birth experience (74%).

4.3.2.15 Reasons for being fully satisfied, partially satisfied and not satisfied with the birth experience

Reasons for being fully satisfied, partially satisfied and not satisfied with the birth experience are reflected on table 4.15.

Table 4.15: Reasons for being fully satisfied, partially satisfied and not satisfied with the birth experience

Themes	Numbers	Percentage %	Mothers experiences of birth
			Explanations
Fully satisfied	259	75.2	**Maternal** • I had no tear no complications. • I had body massages that relaxed my body. • I was learning new information. • I was with my family that comforted me and encouraged me. • I felt safe. • The helper was communicating all the way through the birth process and she was steady and gentle. • Happy for my twins. **Infant** • Baby born alive. • Baby well. • Cord dried in two days.

Themes	Numbers	Percentage %	Mothers experiences of birth
Partially satisfied	43	12.4	**Maternal** • Tear painful. • The birth came as a surprise/I was not ready for birth. • I was given warm water to sit on to soothe painful tear.
Not satisfied	42	12.4	**Maternal** • Too much blood loss. • Scared when I saw placenta retained. • Fad up, panicking and stressed during birth

Table 4.15 shows that most mothers (75%) were fully satisfied with the birth experience.

4.3.2.16 Own experiences of the birth process

Own experiences of the birth process are reflected on table 4.16

Table 4.16: Own experiences of the birth process

Themes	Own experiences		
Birth experience	Number	Percentage %	Explanations
Good experience	259	75.2	• I had no tear no complications after birth. • I was well after birth. • I was in control of the birth process. • I was comfortable squarting during the birth of my baby. .
Average experience	43	12.4	• I was given warm water to sit on to soothe my painful tear.

Themes	Own experiences		
Birth experience	**Number**	**Percentage %**	**Explanations**
Horrible experience	42	12.4	• I was alone – frightened. • I was panicking, stressed, as this was my first experience.
Satisfaction with self	302	87.6	• Satisfied that the birth was a success. • Happy I was well. • Happy I had a baby outside health facility. • Satisfied that baby is well. • Satisfied about the helper.

Table 4.16 shows that most mothers were satisfied with themselves (87%) and that they had a good birth experience.

4.3.2.17 First visit to the health facility

The first visit to the health facility is reflected on figure 4.5

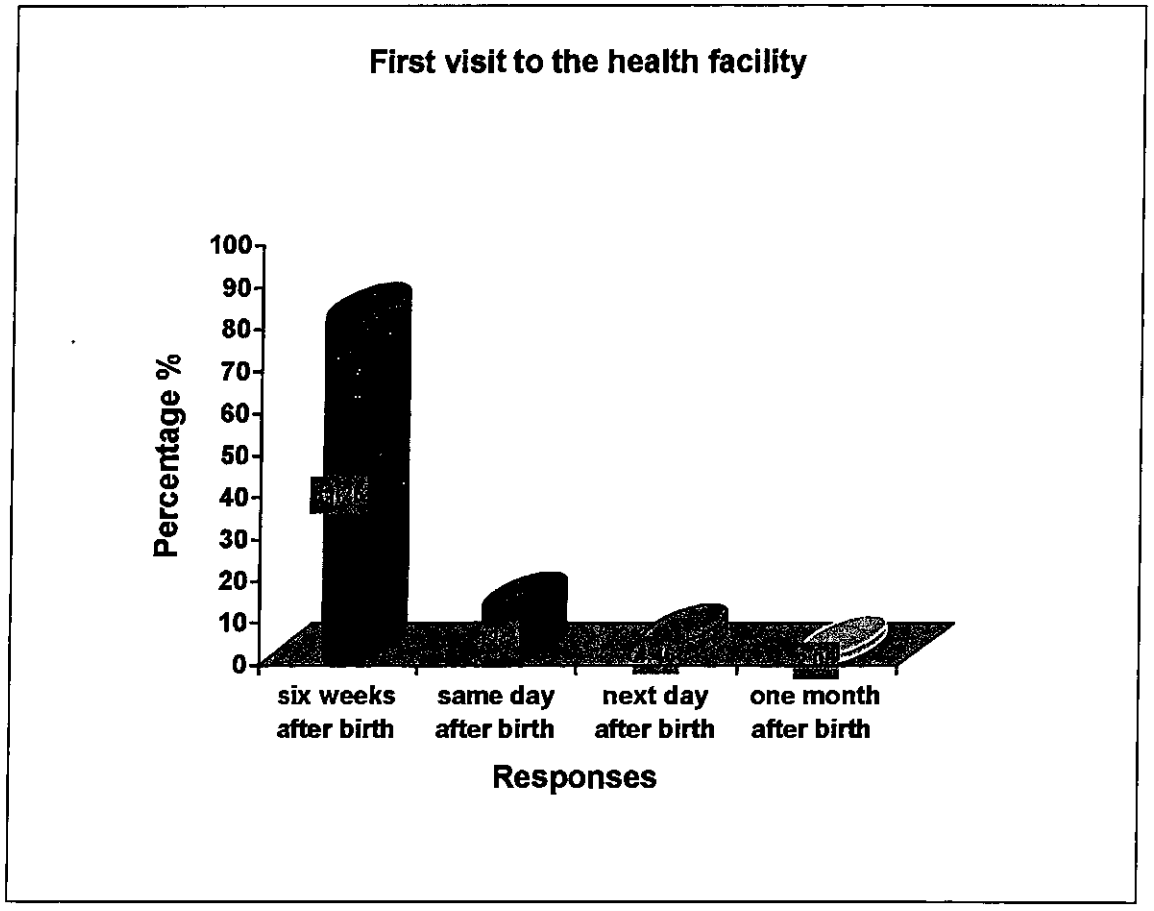


Figure 4.5: First visit to health facility

Figure 4.5 reveals that most women visited the health facility six weeks after birth (81%) however some babies still do not receive postnatal care.

4.3.2.18 Involvement of the partner (husband) during the birth process

The involvement of the partner (husband) during the birth process is reflected on table 4.17.

Table 4.17: The involvement of the partner (husband) during the birth process

The involvement of the partner	Number of participants	Percentage %
Willingness to stand by for emergency	161	46.80
Willingness to ask other men to help him	57	16.57
Willingness to make/fetch stretcher	11	3.20
Willingness to find and pay for transport	10	2.91
Husbands not at home	105	30.5

Table 4.17 shows that partners (husbands) (47%) were willing to stand by for emergency. Other partners/husbands were not at home (31%) (working in RSA, cattle post or in towns).

4.3.2.19 Satisfaction of partner (husband) with birth outside health facility

Satisfaction of partner (Husband) with birth outside health facility is reflected on figure 4.6.

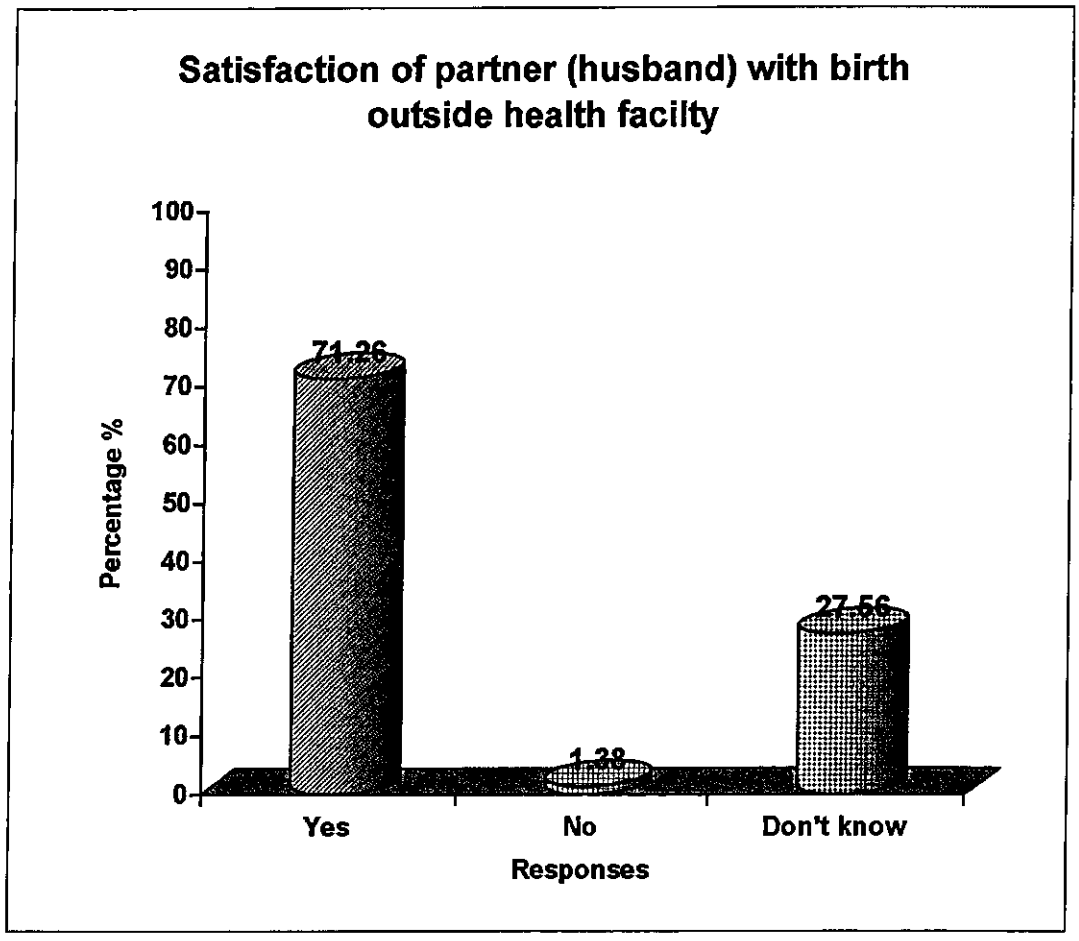


Figure 4.6: Satisfaction of partner (husband) with birth outside health facility

Figure 4.5 shows that most partners (husbands) (71%) were satisfied with birth outside health facility although 27% did not ask their partners.

4.3.2.20 Reasons why partner (husbands) were satisfied with birth outside health facility

Reasons why partner (husbands) were satisfied with birth outside health facility are reflected on table 4.18.

Table 4.18: Reasons why partner (husbands) were satisfied with birth outside health facility

Themes	Number	Percentage %	Explanations
Satisfied	321	93.32	**Mother** • Mother well • There was communication with helper with knowledge sharing. **Outcomes** • The sex of the baby being a boy. • There was immediate feedback to partner about the outcomes of birth. **Baby** • Baby well. • This baby replaced the one who died. **Partner** • Partner rushed wife to hospital for suturing no scolding by nurses. • Husband preferred to have a boy.
Not satisfied	23	6.68	• Nurses were not at the health facility. • The gate of the health facility was locked. • There was no transport to refer the mother to a higher level of care.

Table 4.18 shows that most partners (husbands) were satisfied with the birth outside the health facility.

4.3.2.21 Presence of cultural practices during the birth process

The presence of cultural practices during birth are reflected on figure 4.7

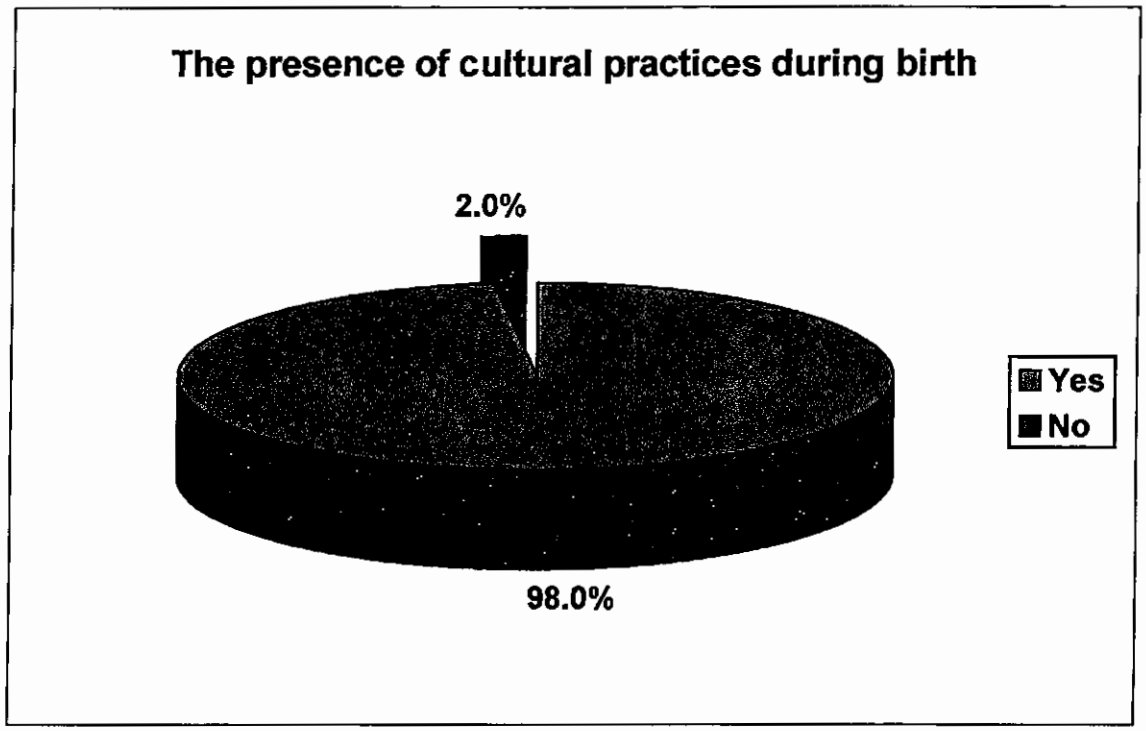


Figure 4.7: Presence of cultural practices during birth

Figure 4.7 shows that only 2% births were involved with cultural practices during the birth process.

4.3.2.22 Presence of cultural practices during the birth process

Presence of cultural practices during the birth process are reflected on table 4.19.

Table 4.19: Presence of cultural practices during the birth process

Themes	Number	Percentage %	Explanations
Practices involved: • Mother • Baby • Infant feeding	7	2	**Mother** • Burial of placenta and cord in the house. • Mother is smeared with red ochre the whole body after birth, while she is rooming in for three months. • Lying in bed until cord is off. • Visiting of outsiders not allowed while mother is rooming in. **Baby** • Baby is not seen by outsiders before cord is off. • Baby bath has drops of mothers milk. • Baby's hair is not shaved until cord is off. • Baby smeared with red ochre until cord is off.
			Infant feeding • Breastfeeding delayed (baby is given clear water, water with sugar, wheat porridge) as first fluids for the newborn. • Cord is treated with sand, ash and grounded powder from some stone known by the elders.

Table 4.19 shows that 2% of the mothers and their babies were involved in cultural practices ranging from burial of placenta in the house, rooming in for three months and outsiders not allowed (protecting the baby from evil spirits and infections) delaying breastfeeding and treating the cord with sand, ash and powders.

4.4 SUMMARY

In this chapter the explanation of the data obtained from the semi-structured interviews was stated comprehensively and in full. According to the data most mothers give birth at home with the help of their mothers because of choice. The outcomes were mostly positive for mother and baby and most mothers experienced birth outside health facility as positive.

The findings and recommendations will be discussed in the following chapter.

CHAPTER 5

FINDINGS, CONCLUSIONS AND RECOMMENDATIONS OF THE STUDY

5.1 INTRODUCTION

As the purpose of the study was to explore births outside health facilities in Lesotho, the importance of this chapter lies in the discussion of the findings and in the making of recommendations.

5.2 FINDINGS OF THE STUDY

Based on the results of the study as portrayed in the previous chapter, the following findings were made:

- Most of the mothers (99%) preferred to give birth at home due to the support given to them from family members. This decision was taken in the light of mothers' previous negative birth experiences in hospitals or their positive birth experience at home.

- All mothers who gave birth outside a health facility were assisted by unskilled family members, predominantly their own mothers. Other unskilled helpers who also assisted were the grand mother, sister, aunt or mother-in-law. Regardless of this fact, most mothers (74%) experienced the care rendered by these unskilled family members as extremely positive due to the fact that a well mother and baby was the birth outcome as well as the support that they received from family members.

- Almost all the mothers indicated that they adhered to cultural practices during the birth process, like walking about, squatting during birth and being surrounded by family members. After the birth the following cultural practices were also adhered to like the burial of the cord and the placenta in the house as well as not allowing outsiders to see the baby until the cord has fallen off - practices not allowed in health facilities.

- Cultural practices regarding infant feeding were implemented because mothers delayed the first feed for a period of time or gave the baby water or wheat porridge as the first feed.

- All mothers indicated that no complications occurred during the birth process, including the teenage mothers (11%).

- Male involvement is limited because culturally husbands are not allowed to support their wives during labor whether it is at home or in a hospital. The men in this study were only prepared to help in cases of emergency, like arranging for transport or fetching help.

- During their antenatal care all mothers received information on the different types of birth such as vaginal birth, caesarean section or forceps delivery, but no information was given regarding what to do in cases of a home birth.

5.3 DISCUSSIONS OF THE CONCLUSIONS

In the light of the findings the following conclusions were made:

5.3.1 The mother's previous birth experience plays a dominant role in her choice regarding where to give birth

Chowdhury (2007) stated that maternal health services play a critical role in the improvement of reproductive health as access to skilled assistance and well equipped health facilities during birth can reduce maternal mortality and morbidity. The care in health facilities is mostly based on technology and instrumental care delivery but holistic care that include aspects such as emotional support, sympathy and rapport are not practiced by health care professionals. This cognitive scientific way of care rendering left the mother feeling empty, alone and powerless. During labor women are vulnerable and if carers are rude, unkind or uncaring they will become frightened and unhappy. If health personnel do not treat mothers with respect and in a judgemental way, the personnel are perceived as uncaring by mothers and that will discourage mothers to seek health care even if this act put them at risk (Safe Motherhood newsletter, 1996)

These feelings of loneliness and lack of support is further enhanced by the shortage of health personnel to care properly for mothers in labor. The shortage of health personnel is caused by resignations, available positions are not filled due to lack of funds, health personnel do not want to be deployed to rural areas and because labour practices such as promotions whereby only those in the low lands are favoured. This shortage of personnel contributes to burnout amongst those health personnel who continue to work as they have to work long hours without a break, rendering of care to fifty or more patients at a time and without enough supplies and commodities. Because of this, health personnel are not in a position to render quality health care resulting in negative birth experiences for mothers. Due to the fact that women remember what happened to them during

labor for the rest of their lives, they may decide to rather give birth at home (Kitzinger 2000:138).

5.3.2 Own home environment is the birth place of choice of the mothers

The finding of this study that mothers prefer their own home setting is affirmed by Kitzinger (2000:12). This author states that the home as place of birth is not strange or new as women in all cultures across the world have been giving birth at home since the beginning of time. Being at home provides the mother with her own quiet space, surrounded by familiar objects in which she can trust her body and give birth with loving support in a way that she feels is right for her. This is in contrast to the hospital delivery room, which is busy and noisy and where the mother is virtually on display on a delivery table surrounded by technical equipment. The mother's own home as place of birth is also supported by Martel (2001:148) by stating that labouring women should not be removed from their own environment where she is in the company of familiar family members, persons she knows well, because her own home is where she feels safe and supported. The support persons at home provide the care that she needs during labor as well as the care that she needs to recover after the birth (Packson, 1994:44). As such, the feeling of being supported plays a critical role in the positive experience of the birth process. This supports the findings of this study as the mothers stated that they were satisfied with their birth experience due to the support that they received during labor.

Another reason why mothers prefer to give birth at home is the risk of infections in hospitals due to various interventions and the over-crowding of hospital wards. Martel (2001:148) indicated that the home environment of the mother is preferable to the hospital environment because at home mothers are not being

exposed to the foreign microbes of the hospital resulting in less puerperal sepsis and neonatal infections when giving birth at home.

5.3.3 Positive birth outcomes when giving birth outside a health facility

Due to possible complications that can develop during labor, it was recommended since the 17th century that women should give birth in a hospital. In the hospital environment it is easier to control the outcome of the birth process with different interventions and in case of emergencies; skilled help is immediately available (Kitzinger 2000:79). This belief resulted in the perception that home births are dangerous and not advisable. In the light of the findings of this study that no complications were experienced by the mothers as well as the fact that they did not receive any information on what to do in case of a home birth, the following positive outcomes were reported by all mothers:

- all babies were born alive including two babies who were born after cord prolapsed had occurred;
- although one baby was a breech baby the baby was born alive and without any complications
- very little blood loss (one hand full) was experienced by most mothers;
- The placentas delivered spontaneously and within the first hour after birth. As mothers buried their placentas at home all mothers felt good because they could honour cultural practices.
- The majority of mothers felt satisfied with themselves as they gave birth without perineal tears. The few that did have a perineal tear were glad that it was sutured at the health facility while one mother was grateful that she was sutured at home by a retired midwife.

In a study done by Janssen, Shoo, Ryan, Duncan and Relmer in 2007 the researchers found that when a comparison was done regarding complications in birth outcomes of planned home births versus planned hospital births, no statistical difference was found in the two birth environments.

5.3.4 Birth attendants available in communities

According to maternal statistics in Maseru, birth attendants at community level are mostly unskilled persons like mothers, mother-in law, sisters, aunts, neighbours, traditional healers, medicine men/women and traditional birth attendants. Most mothers prefer to use these available birth attendants because they are readily available to attend to pregnant and birthing mothers. Because they are nearby, mothers do not need transport and do not have to travel to an unfamiliar place. Their care last longer than the care rendered in hospitals as they stay after birth with the mother to assist her with her household chores and the cultural upbringing of the child. Not only are these birth attendants supportive but they also attend to the emotional, spiritual and cultural as well as religious dimension of the mother as a human being (Chalmers, 1990:67). All mothers were satisfied with the care rendered by these attendants regardless of the fact that they lack professionally trained knowledge and skills to identify problems during pregnancy, birth and the post partum period. According to Perez and Snedeker (1994:8) to give birth is often an uncertain time in a mother's life and the presence of a familiar person (cultural familiar as well as known to her in person) is a way to bring order and control over a chaotic time and event. These persons offer the reassurance and security the new mother needs to relax when giving birth to her baby.

Although professional health care attendants are available at community health levels, these skilled attendants still make use of technology, medical interventions and invasive procedures and do not operates within the indigenous

and spiritual realm. With the result that mothers prefer to give birth in a known and familiar environment – at home.

5.3.5 Culture and cultural practices play an important role in the mother's decision regarding the place of birth

As human beings all mothers live in the socio-cultural world according to the ethos of their specific culture. As a member of her culture the mother directs her behaviour to the rules laid down by her culture (Van Staden & Du Toit, 1998:4). As such, all traditional African mothers must obey the rules laid down by their culture. The pregnant mother's own mother or mother-in-law will decide where she must give birth - most of the time at home amongst family members. These authority figures have the right to make decisions on behalf of the mother and she is not allowed to question their decisions. If the mother disobeys the authority figures, they will withdraw their support and leave the mother to cope on her own – sometimes even without any financial support (Samovar & Porter, 2000:179).

According to Wick (2002) the African mother has to follow all cultural practices regarding pregnancy and childbirth as well as those practices involved in the upbringing of her child without the involvement of westernized care that is practiced in health care facilities. Therefore, the cultural beliefs regarding infant feeding is still practiced by all mothers who took part in the study – mothers still belief that colostrum is harmful to the newborn thus delaying the first breast feeding for a few days. This practice results in the fact that the baby looses out on the value of colostrum which is rich in antibodies and nutrients that boost the newborn's immune system (Mohrbacher & Stock 1997:56).

Phoofolo (2002:38) found in a study that although in the western society men are choosing to take an increasingly active role in the birth of their babies, in the African cultures men are not allowed to support their wives during labor - strictly a business for women only. Furthermore, in some hospitals only the husband is allowed to stay with the mother in labor and therefore the mother would rather choose to give birth at home amongst familiar female family members than alone in a strange health facility amongst unfamiliar women.

5.4 RECOMMENDATIONS MADE

In order to support the mother's right to choose the place of birth of her baby and to achieve Millennium Goals five and six as set by the World Health Organisation, the following recommendations, based on the findings of the study, are made:

5.4.1 Community level

- **Pregnant women and their support persons**

Women themselves must take responsibility for their own health by attending antenatal care and seek treatment when there is a problem. They also need to attend antenatal education programmes that will help them to identify problems and develop skills in the handling of emergencies (Sears & Sears, 1994:32). During the antenatal visits mothers must also be made aware to arrange in time for transport and money before the birth date of their babies. When mothers attend antenatal education programs they can bring along their mothers or support persons so that they too can be informed about the birth process and how to manage birth in a safe way that will contributes to the health of the mother and baby. Antenatal and childbirth education must form part of the antenatal care provided by the Health Sector that the mother visits during pregnancy.

Community leaders and women's groups can also be involved in educational talks to help reduce maternal and neonatal deaths by informing pregnant mothers of the danger signs during pregnancy as well where to seek help in cases of emergencies. Education and mobilization of community members is important because community members can encourage women with identified pregnancy risks to give birth in a health center.

- **Traditional birth attendant (unskilled helper)**

- Traditional birth attendants (TBA) form part of the community's informal health care system and because they generally hold a position of trust and influence within their communities, they form a valuable link between the community and the health care system. Therefore the involvement of the TBA in maternal and neonatal care can contribute to the survival of mother and baby.

- Training of the TBA should be done not only to ensure clean and safe births but also to recognize dangers signs, to avoid harmful cultural practices and to encourage mothers to go for pregnancy and post partum care in the health centres.

- To prevent TBA's practices to slide back into the old ways, supervision by skilled attendants after training is important. .

- Partnerships that are based on mutual respect and trust must be formed between the TBA and the skilled attendant. In this partnership it is important to protect the TBA's reward (cash or in kind) because if there is a risk that the TBA will loose her reward from the mother, the TBA will not refer her to formal health care when the need arises.

5.4.2 Formal health care setting level

Hospitals and health centres play an important role in the provision of quality and acceptable health care to mothers and babies. Based on the fact that mothers, due to a negative hospital birth experience, prefer to give birth at home, is it imperative that a hospital/health centre environment must be created to enable mother to have a positive hospital birth experience. To address the millennium goals stated by the World Health Organisation for better maternal and child health, the following should be in place in all health sectors that render care to mothers and babies as to create an enabling environment to foster a positive hospital birth experience for women.

- **Health care centres/hospital**

- A set vision and mission that includes culturally congruent birth care and support to mothers in labor given by birth attendants of her choice. If the mother chooses a traditional birth attendant the TBA must work under the supervision of a skilled attendant in a relationship based on mutual trust and respect.

- Enough personnel to ensure safe birthing – that is one skilled helper to one mother in labor to ensure a positive birth experience. According to Perez & Snedeker (1994:13) the TBA can assist skilled helpers with support during labor when they need to care for more than one woman at a time.

- A set of humane values and norms to be followed by skilled helpers regarding the mother-baby-family as human beings that are a family unit that needs to be protected and cherished.

- A physical environment that not only ensure quality care, dignity and privacy to the mother in labor, but also avail itself for accepting family members as support persons during labor.

- A corporate/organizational culture that encourages a mother and family-skilled-helper relationship and the therapeutic use of the skilled helper within the boundaries of this relationship.

- A system that ensures culturally congruent evidence-based care must be developed in the health care settings - during the midwifery care assessment, care diagnosis (wellness, high risk and needs-based) and midwifery interventions planned and executed.

- Developing control measures that indicate patient satisfaction in an effort to ensure the rendering of compassionate, comprehensive, holistic, evidence based and culturally congruent midwifery care to mothers, babies and families.

- Medical audits must be done on a regular basis to identify and address problematic areas in order to improve maternal and neonatal care.

- National policies must be set regarding the specific midwifery skills that skilled attendants must have in rural areas so that they can assist in cases of emergencies or supervise the TBA or assist the mother when she chooses to give birth at home.

Skilled attendant

- Skilled attendance must apply their curative (core) skills within the caring relationship in such a way that the focus is on the mother and not on the provider of maternal health care.

- To humanize the birth experience, skilled attendants must be caring in their behaviour and be responsive to the mother's needs as communicated by her – either verbal or nonverbally. The mother must be accepted as an active participant in the birth process and be part of the decision making process.

- Culturally accepted practices/procedures must be followed by the skilled helper for example the handling of the placenta, feeding of the baby and care of the mother and baby.

- In service training programmes for skilled helpers must be in place to ensure that they render compassionate, comprehensive holistic, evidence-based and culturally congruent maternal and neonatal health care.

- Although skilled helpers play a key role in the reduction of maternal and neonatal mortality, working with the community is important. Regular meetings with important stakeholders in the community like the TBA regarding maternal and neonatal health will help convey vital health messages to families in a culturally appropriate way.

5.4.3 Further research to be done

Based on the findings of the study further research is needed regarding the following:

- Strategies to develop proper demographical statistics regarding maternal and neonatal mortality in Lesotho
- Interventions to integrate the care of skilled and unskilled attendants to enhance positive birth experiences and birth outcomes.

5.4 SUMMARY

In this chapter the findings of the study were highlighted as well as the conclusions were discussed. Recommendations regarding the improvement of the mother's birth experience and outcomes regardless of the birth place, were made.

CHAPTER 6

SUMMARY OF THE STUDY

According to the Ministry of Health/Social Welfare, 95% of all pregnant women attend ante-natal care at the health facility provided by skilled providers (MOH/SW, 2003:17). However, less than 50% of those pregnant women give birth at the health facility.

The aim of the study was to describe births outside a health facility as a phenomenon. The objectives were to identify the place of birth outside a health facility, identify who the helper/attendant was during the birth, identify the reasons why the women gave birth at home, explore the mothers experiences regarding the birth, the outcomes of the health process, and describe cultural practices adhered to during birth.

A non-experimental descriptive and exploratory design with a survey as a method was used. A semi-structured interview with an interview schedule with closed ended and open ended questions were used to gather data. A purpose sampling method was used to select 8 health facilities in the Maseru Health Service Area as well as 344 respondents for the study. Ethical principles relevant to conduct research involving human subjects was adhered to, such as obtaining the necessary permission to enter the field and complying with the human rights of the respondents. Semi-structured interviews were used to collect data from respondents of all ages, living in town, peri-urban and rural settings of Maseru Health Service Area. The methodology of the study was simply but thoroughly explained.

The results of the study showed that women gave birth at home, assisted by their mother or family members. The reasons why they gave birth at home were either intentional (e.g. wanted to be amongst family members) or unintentional (e.g. baby came too fast). The mothers experience regarding the birth was generally good and the outcomes of the birth process were positive because there were no negative consequences for mother and baby.

Mothers gave birth at home with the help of a family member or TBA who sometimes is the only help available in the community and that is why one of the recommendations is to train the community members (e.g. traditional birth attendant) to support safe motherhood as well as the mothers right to choose her own place of birth.

OPSOMMING VAN DIE STUDIE

Volgens die Minister van Gesondheid en Sosiale Welsyn woon 95% van swanger vroue voorgeboorte klinieke vir sorg deur opgeleide gesondheidsorgwerkers by, maar slegs 55% van die swanger vroue skenk geboorte in 'n gesondheidsorgfasiliteit.

Die doel van die studie is om geboortes buite gesondheidsorgfasiliteite as fenomeen te beskryf. Die gestelde doelwitte is om die plek van geboorte te identifiseer, wie die ondersteuner/helper tydens die geboorte was en die redes waarom vroue tuis kraam. Die moeders se ervaring van die geboorte, die uitkomste van die geboorte wat nie in fasiliteite plaasgevind het nie, asook die kulturele gebruike/gelowe betrokke, was verdere doelwitte van die studie.

'n Nie-eksperimentele ontwerp wat beskrywend en verkennend van aard is, met die opname as metode, is gebruik. Data vanaf die vroue wat buite gesondeheidsorg fasiliteite gekraam het, is deur middel van 'n semi-gestruktureerde onderhoud met die hulp van 'n onderhoud skedule ingesamel. Hierdie skedule het oop sowel as geslote vrae bevat.

'n Doelbewuste steekproef seleksie is gedoen om agt gesondheidsorgfasiliteite wat moeder en baba sorg in Maseru Gesondheidsorg area lewer asook 344 respondente wat nie in gesondheidsorg fasiliteite gekraam het nie, te identifiseer.

Die etiese beginsel met betrekking tot menslike navorsing is nagekom naamlik die nodige toestemming om die navorsingsveld te betreë asook ingeligte toestemming vanaf die respondente is verkry.

Die semi-gestruktureerde onderhoud is met vroue wat aan die insluitingskriteria voldoen het, afkomstig van stedelike sowel as plattelandse areas, gevoer.

Die resultate van die studie toon dat die meeste vroue tuis gekraam het met die ondersteuning van hul moeders of ander familielede. Die hoofredes was dat hul die tuisgeboorte beplan het omdat hul tussen bekende persone wou kraam. Sommige vrouens is oorval deur die kraamproses aangesien hul nie beplan het om tuis te kraam nie. Die meeste moeders het 'n positiewe tuisgeboorte-ervaring gehad en daar was geen negatiewe uitkomste nie, aangesien alle moeders en babas se welstand bevredigend na die kraam was.

Aangesien moeders steeds verkies om tuis te kraam en omrede tradisionele geboorte ondersteuners (TBA) dikwels die enigste persoon wat in die gemeenskap beskikbaar is om te help, is daar verskeie aanbevelings bemaak om die moeder se keuse rakende die geboorteplek van haar baba, te kan ondersteun wat onder andere insluit die opleiding van die TBA.

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ADDENDUM A

UNIVERSITEIT VAN DIE VRYSTAAT
UNIVERSITY OF THE FREE STATE
YUNIVESITHI YA FREISTATA

Addendum A

Addendum

Direkteur: Fakulteitsadministrasie / Director: Faculty Administration
Fakulteit Gesondheidswetenskappe / Faculty of Health Sciences

Research Division
Internal Post Box G40
☎(051) 4052812
Fax nr (051) 4444359

E-mail address: gndkhs.md@mail.uovs.ac.za

Ms H Strauss

2005-09-15

MS EM SEIPOBI
HA TSIU
P O BOX 362
MASERU
100

Dear Ms Seipobi

ETOVS NR 184/05
RESEARCHER: MS EM SEIPOBI
PROJECT TITLE: BIRTHS OUTSIDE HEALTH FACILITIES IN MASERU HEALTH SERVICE AREA - LESOTHO

You are hereby informed that the Ethics Committee approved the above-mentioned study during their meeting held on 13 September 2005.

Your attention is kindly drawn to the following:

- A progress/final report have to be submitted after completion of the study or within a year after approval of the project
- That all extentions, amendments, serious adverse events, termination of a study etc have to be reported to the Ethics Committee
- These documents have been accepted as complying with the Ethics Standards for Clinical Research based on FDA, ICH GCP and Declaration of Helsinki guidelines as well as the Clinical Trials Guidelines 2000: Dept of Health RSA and MRC Guidelines on Ethics for Medical Research

Will you please quote the Etovs number as indicated above in subsequent correspondence, reports and enquiries.

Yours faithfully

DIRECTOR: FACULTY ADMINISTRATION

ADDENDUM B

Addendum B

Ministry of Health & Social Welfare
P.O. Box 514
MASERU 100
24TH May 2005

Mrs. M. Seipabi
P.O. Box 302
MASERU 100

Dear Madam,

Re: RESEARCH ON BIRTHS OUTSIDE HEALTH FACILITIES IN MASERU HEALTH SERVICE AREA – LESOTHO

Your proposal to do the above study has been reviewed by the Ministry of Health and Social Welfare.

You are given approval to carry out the study and you are expected to share the findings of this study with the Family Health Division of the Ministry of Health and Social Welfare.

We wish you good luck in your endeavour.

DR. T. MOOROSI
DIRECTOR GENERAL OF HEALTH SERVICES

ADDENDUM C

Addendum C

CHAL
CHRISTIAN HEALTH ASSOCIATION OF LESOTHO
TELEPHONE: 22312500 FAX: 22310314 E-mail: Chal@lesoff.co.za
P.O. BOX 1632
MASERU 100, LESOTHO (SOUTHERN AFRICA)

15th February 2005

Mrs. E. M. Seipobi
Ha Tšiu
P. O. Box 362
Maseru 100

Dear Mrs. Seipobi,

RE: REQUEST TO CONDUCT RESEARCH

We acknowledge receipt of your letter dated 15th February 2005.

We have indeed appreciated your topic of research because there is little information on home deliveries and its impact on maternal complication and mortality.

Please make contacts with the Institutions you wish to involve in this study.

Wishing you all the best.

Sincerely,

A. M. Ntholi
DEPUTY EXECUTIVE SECRETARY

ADDENDUM D

Addendum D

INFORMED CONSENT FORM FOR THE INTERVIEW SCHEDULE

STUDY TITLE: BIRTHS OUTSIDE HEALTH FACILIETIES IN THE MASERU HEALTH SERVICE AREA

RESEARCHER: MANTHUOA ESTHER SEIPOBI

CONTACT TELEPHONE NUMBERS: (09266) 22312132/63022715

You are invited to participate in a research study regarding births outside health facility. In the Maseru Health Service Area. You will be requested to participate in an interview which will take approximately 45 minutes.

The study has been approved by the Ethics Committee of the Faculty of Health Sciences of the Free State University. There are no risks involved in responding to the questions. There may be no direct benefits to the participants of this study, but there may be improvements in the safe motherhood program. The outcomes of this study can be used to prevent infant and maternal morbidity and mortality.

Your participation in this study is voluntary and you have the right to withdraw at any time without penalty and your clinic activities will not be affected. You will not get any compensation for your participation.

Your name will not appear in the interview schedule. Study data will be coded so that data will not be linked to you. All study data will be collected by the researcher and stored in a safe place, no one will have accesses to raw data. The final report containing anonymous quotations will be available to all at the end of the study in the form of publications and baseline data to the Government of Lesotho.

I have read this concent form and voluntarily concent to participate in this study.

---------- ----------

Participant's signature Date

The following must be completed in cases where the mother is younger than 18 years

I ---------- The Parent/Guardian of ----------

gives concent that she can participate in the research study

I have explained this study to the above participant and have sought her understanding for informed concent

---------- ---------- ----------

Researcher's signature Date

ADDENDUM E

Addendum E

FOROMO HA UNKA KAROLO LIPHUPUTSONG

Sehloho: Ho pepela kantle ho motebo oa litlhare tikolohong ea Maseru

Mofuputsi: 'Manthuoa Esther Seipobi
Fono: (09266) 22312132/ 63002715

U memeloa ho nka karolo liphuputsong mabapi le bakhachane ba pepelang ka ntle ho motebo oa litlhare. U tla koptjoa ho araba lipotso tse tla nka metsotso e mashome a mane le metso e mehlano.

Univesiti ea Foreisitata ka lekala la mahlele bophelong le komiti ea molao e lumetse hore liphuputso tsena li ka tsoela pele. Ha ho kenngoe motho mathateng ha u arabna lipotso. Ha ho molemo oo u tla u fumana ha u nka karolo liphuputsong tsena, empa ho tla ba le ntšetsopele litšebeletsong tsa bo-'m' a le masea. Lihlahisoa tsa liphuputso tsena li ka phema ho kula le ho hlokahala ha bo-'m'a le masea.

Ho nka karolo liphuputsong ke ka boithaopo e bile u na le tokelo ea ho itokolla ka nako efe kapa efe ho se kotlo ea letho e ka amang ho tla ha hau litšebeletsong setsing sa motebo oa litlhare. U keke oa fumana moputso oa letho ha u nka karolo liphuputsong tsena.

Lebitso la hau le keke la hlaha lethathamong la lipotso. Taba tse fumanoeng li tla hokangoa le hore li seke tsa amana le oena, taba tsohle tse fumanoeng li tla bokelloa ke mofuputsi 'me li tla bolokoa li tšireletsehiloe. Ha ho motho ea tla fumana monyetla oa tsona. Tlaleho ea ho qeletela e nang le liqeto tse sa amaneng le mang kapa mang e tla fumaneha ho boohle qetellong ka mokhoa oa li-ngoliloeng le tse fumanoang lipatlisisong ho "Muaso oa Lesotho.

_____ _____

Ea nkang karolo oa tekena Letsatsi

Karolo ena e tla tlasoa ha 'Me ele ea lilemong tse ka tlase ho 18.

'Na_____ Motsoali/Mohlokomeli oa _____

Ke fana ka tumello hore a nke karolo liphuputsong tsena, ke bile ke entse bonnte ba hore abe le kutluisiso ha a lumela honka karolo.

_____ _____

Mofuputsi oa tekena Letsatsi

ADDENDUM F

The interview schedule

SECTION A

BIOGRAPHIC

For office use only

1. Name of health facility

Queen Elizabeth II MCH Clinic	1	
Qoaling Filter Clinic	2	
Matukeng	3	
Maseru Private	4	
Makoanyane	5	
Bethany Clinic	6	
Holy Family	7	
Khubetsoana	8	
Good Shepard Clinic	9	[ ] 4

2. Place of residence

Town	1	
Peri-urban	2	
Rural	3	[ ] 5

3. How old are you?

_____ years [ ][ ] 6 - 7

4. Marital status

Married	1	
Single	2	
Widowed	3	
Divorced	4	
Living together	5	[ ] 8

5. How many children do you have?

_____ [ ][ ] 9 – 10

6. Birth order of this child?

_____ [ ] 11

7. How many children were born outside a health facility?

_____ [ ] 12

For office use only

7.1 Why were they born outside health facility?

_____ 13 – 14

_____

8. Religious denomination

Roman Catholic	1
Lesotho Evangelical Church	2
Anglican	3
Methodist	4
Seventh Day Adventist	5
Other (specify) _____	6

15

9. Level of education

Primary	1
High school	2
Tertiary	3
No schooling	4

16

10. Are you employed?

Yes	1
No	2

17

11. If Yes, does your earnings enable you to meet your needs?

Fully	1
Partially	2
Not at all	3

18

12. If No, do you receive financial support?

Yes	1
No	2

19

13. If Yes, from whom?

_____ 20 – 21

_____

SECTION B

HEALTH SERVICES

For office use only

14. During your visits at the health facility, did the health providers discuss with you available birth services?

Yes	1	
No	2	
Don't know	3	☐ 22

15. If Yes, did they tell you about:

Normal birth	1	☐ 23
Birth by forceps	2	☐ 24
Birth through abdomen	3	☐ 25

16. Where did you have your baby - at home?

Yes	1	
No	2	☐ 26

16.1 If Yes, why did you have your baby at home?

_____

_____ ☐☐ 27 – 28

16.2 If No, why did you not have your baby at home?

_____

_____ ☐☐ 29 – 30

16.3 I had my baby on the way to the health facility?

Yes	1	
No	2	☐ 31

16.4 If Yes, why did you have baby on the way to health facility?

_____

_____ ☐☐ 32 – 33

16.5 I had my baby in the public transport

Yes	1	
No	2	☐ 34

For office use only

16.6 If Yes, why did you have the baby in the public transport

_____

_____ 35 – 36

16.7 I had my baby at traditional health place

Yes	1
No	2

37

16.8 If Yes, why did you have the baby at traditional healers place?

_____

_____ 38 – 39

16.9 I had my baby at traditional birth attendants place

Yes	1
No	2

40

16.10 I had my baby at other places

_____

_____ 41 – 42

17. Was this your place of choice?

Yes	1
No	2

43

17.1 If Yes, why did you have the baby at traditional healers place?

_____

_____ 44 – 45

17.2 If No, why was this not your place of choice?

_____

_____ 46 – 47

18. What stopped you from going to a health facility for birth?

Health facility too far	1	48
Had no money	2	49
Baby come too fast	3	50
Not treated well last time	4	51
Other (specify)	5	52

For office use only

19. Who advised you to give birth outside health facility?

Parents	1	53
Peers	2	54
Husband	3	55
Boyfriend	4	56
Nurses	5	57
Self	6	58
Other, specify _____	7	59

20. Did your mother assist you during labour?

Yes	1	
No	2	60

20.1 If Yes, why did your mother assist you?

_____

_____ 61 – 62

20.2 If No, why did your mother not assist during labour?

_____

_____ 63 – 64

20.3 Friend assisted your during labour?

Yes	1	
No	2	65

20.4 If Yes, why did your friend assist you during labour?

_____

_____ 66 – 67

20.5 Traditional birth attendant assisted during labour?

Yes	1	
No	2	68

20.6 If Yes, why did traditional birth attendant assist you during labour?

_____

_____ 69 – 70

20.7 Neighbour assisted during labour?

Yes	1	
No	2	71

For office use only

20.8 If Yes, why did neighbour assist you during labour?

_____

_____ | | 72 – 73

20.9 Traditional healer assisted during labour?

Yes	1
No	2

| | 74

20.10 Others assisted during labour?

Yes	1
No	2

| | 75

20.11 If Yes, who were these?

_____

_____ | | 76 – 77

20.12 Why did they have to assist during labour?

_____

_____ | | 78 – 79

20.13 When did your assistant arrive?

Before the time	1
When the contractions started	2
When the head was out	3
After the birth of the baby	4

| | 80

20.14 Did you arrange for somebody to assist you?

Yes	1
No	2

| | 1

20.15 If Yes, who did you arrange with to assist you?

_____

_____ | | 2 – 3

20.16 Was this person on time?

Yes	1
No	2

| | 4

For office use only

21. **Mother:**
During birth process did the following happen?

21.1 Baby comes out wrong (feet or buttocks first)

Yes	1
No	2

☐ 5

21.2 If Yes, explain what happened?

_____

_____

☐☐ 6 – 7

21.3 Did the head come out first?

Yes	1
No	2

☐ 8

21.4 If No, what came out first? Explain

_____

_____

☐☐ 9 -10

21.5 Body of baby followed head

Yes	1
No	2

☐ 11

21.6 If No, what followed the head of baby?

_____

_____

☐☐ 12 - 13

21.7 Was there little bleeding?

Yes	1
No	2

☐ 14

21.8 If No, how much blood was lost? explain

_____

_____

☐☐ 15 – 16

21.9 Did the placenta come out immediately?

Yes	1
No	2

☐ 17

For office use only

21.10 If No, how long did it take for placenta to come out?

30 minutes after birth of baby	1
1 hour after birth of baby	2
2 hours after birth of baby	3
3 hours after birth of baby	4
The placenta stayed behind	5

[ ] 18

21.10.1 Did the placenta come out on its own?

Yes	1
No	2

[ ] 19

21.10.2 If No, how was the placenta assisted to come out? Explain

_____

_____

[ ][ ] 20 – 21

21.10.3 What did the helper do with the placenta?

Buried by helper	1
Buried by mother	2
Buried by family elder	3
Other (specify) _____	4

[ ] 22

21.11 Was there a tear?

Yes	1
No	2

[ ] 23

21.11.1 If Yes, was the tear sutured?

Yes	1
No	2

[ ] 24

21.11.2 Where was the tear sutured?

_____

_____

[ ][ ] 25 – 26

21.12 Was the baby born alive?

Yes	1
No	2

[ ] 27

21.13 Was the baby born without a loud cry?

Yes	1
No	2

[ ] 28

For office use only

21.13.1 If Yes, what was done to stimulate the baby to cry loud?

_____ ☐☐ 29 – 30

_____

21.14 Was the baby born floppy?

Yes	1
No	2

☐ 31

21.14.1 If Yes, what was done to resuscitate the baby?

_____ ☐☐ 32 – 33

_____

21.14.2 Did the baby survive?

Yes	1
No	2

☐ 34

21.15 Did the cord fall out first before the baby?

Yes	1
No	2

☐ 35

21.15.1 If Yes, how did the helper manage this situation?

_____ ☐☐ 36 – 37

_____

Baby:

22. Did the helper clean the mouth?

Yes	1
No	2
Don't know	3

☐ 38

23. What was used to clean the mouth?

Helper's mouth	1
Helper's finger	2
Cloth	3
Don't know	4

☐ 39

24. Did the baby cry immediately?

Yes	1
No	2
Don't know	3

☐ 40

For office use only

Explain your answer _____ ☐☐ 41 – 42

25. Did the helper cut the cord?

Yes	1
No	2

☐ 43

25.1 If Yes, what was used? _____ ☐☐ 44 - 45

25.2 If No, what happened? _____ ☐☐ 46 – 47

26. Did the helper clamp the cord?

Yes	1
No	2
Don't know	3

☐ 48

27. What was used to clamp the cord? _____ ☐☐ 49 – 50

28. What was applied on the cord?

Cow dung	1	☐ 51
Vaseline	2	☐ 52
Sand	3	☐ 53
Ash	4	☐ 54
Don't know	5	☐ 55

29. Did the helper wipe the baby dry?

Yes	1	
No	2	
Don't know	3	☐ 56

30. Was the baby wrapped warm?

Yes	1	
No	2	
Don't know	3	☐ 57

31. What was used to keep the baby warm?

Baby wrapper	1	☐ 58
Mother's blanket	2	☐ 59
Mother's abdomen	3	☐ 60
Other (specify)_____	4	☐ 61

For office use only

32. Where was the baby kept after birth?

With mother	1
Away from mother	2
Other places	3

[ ] 62

33. What was the first thing given to the baby to swallow?

Clean water	1
Water with sugar	2
Breast milk	3
Other (specify) _____	4

[ ] 63

34. When was it given?

Within one hour	1
After one hour	2
After three hours	3
Other (specify) _____	4

[ ] 64

35. When did the baby first suck from the breast?

Immediately after birth	1
After one hour	2
After three hours	3
Other (specify) _____	4

[ ] 65

36. What happened to you after birth?

Walked home	1	[ ] 66
Made to sleep comfortably	2	[ ] 67
Had a bath	3	[ ] 68
Given food to eat	4	[ ] 69
Went to health facility	5	[ ] 70
Other (specify) _____	6	[ ] 71

37. Did the helper use protective clothing such as:

Gloves	1	[ ] 72
Plastic bags for gloves	2	[ ] 73
Plastic apron	3	[ ] 74
Others (explain) _____	4	[ ] 75

38. Were there cultural practices involved during the birth process?

Yes	1	
No	2	[ ] 76

For office use only

38.1 Explain what was involved for the mother

_____
_____
_____

77 - 78
79 - 80

38.2 Explain what was involved for the baby?

_____
_____
_____

1 – 4

39. Were you satisfied with the birth experience?

Fully	1
Partially	2
Not satisfied	3

5

39.1 Give reasons for your response

_____
_____
_____

6 – 7
8 – 9
10 – 11

40. How did you experience this birth process?

Good experience	1
Average experience	2
Horrible experience	3
Fearful	4

12

41. Were you satisfied with yourself?

Yes	1
No	2

13

41.1 If Yes, were you:

Satisfied that you had a birth outside health facility	1	14
That birth was a success	2	15
Happy that you are well	3	16
Satisfied that baby is well	4	17
Satisfied about the helper	5	18
Other (specify) _____	6	19

41.2 If No, explain

_____
_____

20 – 21

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42. When was your first visit to the health facility after birth?

Same day after birth	1	
Next day after birth	2	
One month after birth	3	
Six weeks after birth	4	☐ 22

43. Was the partner (husband) involved during the birth process? shown by:

Willingness to stand by for emergency	1	☐ 23
Willingness to ask other men to help him	2	☐ 24
Willingness to make/fetch stretcher	3	☐ 25
Willingness to find and pay for transport	4	☐ 26
Attended birth	5	☐ 27
Other (specify) _____	6	☐ 28

44. Was the partner (husband) satisfied with birth outside the health facility?

Yes	1	
No	2	
Don't know	3	☐ 29

44.1 Explain

_____

_____

_____

☐☐ 30 – 31

☐☐ 32 – 33

Thank you for participating

ADDENDUM G

Lethathamo la Lipotso

SECTION A

BIOGRAPHIC

For office use only ☐☐☐ 1 - 3

1. Lebitso la Motebo

Queen Elizabeth II MCH Clinic	1
Qoaling Filter Clinic	2
Matukeng	3
Maseru Private	4
Makoanyane	5
Bethany Clinic	6
Holy Family	7
Khubetsoana	8
Good Shepard Clinic	9

☐ 4

2. Moo u lulang

Town	1
Peri-urban	2
Rural	3

☐ 5

3. Lilemo ta hau likae?

_____ years ☐☐ 6 - 7

4. Boemo ba lenyalo

Married	1
Single	2
Widowed	3
Divorced	4
Living together	5

☐ 8

5. U na le bana ba bakae?

_____ ☐☐ 9 – 10

6. Ngoana eo ke oa bokae?

_____ ☐ 11

7. Ke bana ba bakae ba hlahetseng kantle ho motebo?

_____ ☐ 12

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7.1 Hobaneng ba ile ba hlahela kantle ho motebo?

_____ 13 – 14

_____

8. Bolumeli

Roman Catholic	1
Lesotho Evangelical Church	2
Anglican	3
Methodist	4
Seventh Day Adventist	5
Other (specify) _____	6

15

9. Boemo ba thuto

Primary	1
High school	2
Tertiary	3
No schooling	4

16

10. Na ua sebetsa?

Ee	1
Chee	2

17

11. Haeba u sebetsa,moputso oa hau o lekane?

Ka ho tlala	1
Ka 'moho	2
Ho hang	3

18

12. Haeba chee Na u fumana lithuso?

Ee	1
Chee	2

19

13. Haeba Ee Li tsoa ho mang?

_____ 20 – 21

_____

SECTION B

Litsebeletso tsa Bophelo

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14. Ketelong ea hau motebong, Na basebetsi ba ile ba buisana le uena ka litsebeleso tsa pelehi tse teng?

Ee	1	
Chee	2	
Ha ke tsebe	3	☐ 22

15. Haeba Ee, Na ba ile ba u bolela ka tsena:

Ho pepa hantle	1	☐ 23
Ho pepa ka litsepe	2	☐ 24
Ho pepa ka thipa	3	☐ 25

16. U ile oa pepela kae, Lapeng?

Ee	1	
Chee	2	☐ 26

16.1 Haeba ee, Hobaneng u ileng oa pepela hae?

_____ ☐☐ 27 – 28

_____

16.2 Haeba chee, Hobaneng U sa kang oa pepela hae?

_____ ☐☐ 29 – 30

_____

16.3 Ke ile ka ka khauletsoa ke ea motebong?

Ee	1	
Chee	2	☐ 31

16.4 Hobaneng u ile oa khaoletsoa u ea motebong?

_____ ☐☐ 32 – 33

_____

16.5 Ke ile ka pepela koloing ea baeti

Ee	1	
Chee	2	☐ 34

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16.6 Ihobang u ile oa pepela koloing ea baeti?

_____ ☐☐ 35 – 36

_____

16.7 Ke ile ka ba le ngoana ha ngaka ea setso

Ee	1
Chee	2

☐ 37

16.8 Hobaneng u ile oa pepela ha ngake ea setdo?

_____ ☐☐ 38 – 39

_____

16.9 Ke ile ka pepela ha mosebeletsi

Ee	1
Chee	2

☐ 40

16.10 Ke ile ke pepela libakeng tse ling

_____ ☐☐ 41 – 42

_____

17. Na e ne ele seba seo u ikhthetseng sona?

Ee	1
Chee	2

☐ 43

17.1 Hobang u ile oa ikhethela ho pepela ha mopepisi?

_____ ☐☐ 44 – 45

_____

17.2 Hobaneng u ne u sa ikhethela ho ea ha mopepisi?

_____ ☐☐ 46 – 47

_____

18. U thibetsoe keng ho pepela motebong oa litlhare?

Motebo o hole	1
Ke haelloa ke chelete	2
Ke ile ka khaoletsoa	3
Ha kea sebeletsoa hantle khetla la pele	4
Tseling, hlalosa	5

☐ 48
☐ 49
☐ 50
☐ 51
☐ 52

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19. Ke mang ea u eletitseng ho pepela ka ntle ho motebo?

Botsoali	1	53
Metsoalle	2	54
Monna	3	55
Mohlankana	4	56
Mooki	5	57
'Na	6	58
Ba bang _____	7	59

20. Na 'me oa hau o ile a u thusa pelehing?

Ee	1	
Chee	2	60

20.1 Hobaneng a ile a u thusa?

_____ 61 – 62

_____

20.2 Haeba chee, hobaneng a sa ka a u thusa?

_____ 63 – 64

_____

20.3 Motsoalle o ile a o thusa pelehing?

Ee	1	
Chee	2	65

20.4 Hobaneng motsoalle a ile a u thusa pelehing?

_____ 66 – 67

_____

20.5 Ngaka ea setso e ile ea u thusa pelehing?

Ee	1	
Chee	2	68

20.6 Haeba ee, hobaneng ngake e ile ea u thusa?

_____ 69 – 70

_____

20.7 Mohaisani u ile a u thusa?

Ee	1	
Chee	2	71

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Haeba ee, hobaneng mohaisane a iel a u thusa?

_____

_____ 72 – 73

20.9 Ngaka ea setso e ile ea u thusa peleing?

Ee	1
Chee	2

74

20.10 Ba bang ba ile ba thusa pelehing?

Ee	1
Chee	2

75

20.11 Haeba ee , e ne ele bo mang?

_____

_____ 76 – 77

20.12 Hobaneng ba ile ba thusa pelehing?

_____

_____ 78 – 79

20.13 Ea neng a u thusa o ile a fihla neng?

Pele ho naka	1
Ha mahlaba a qala	2
Hlooho e se e tsoile	3
Ngoana a se a hlahile	4

80

20.14 Na u ne o lukisitse hore ho be le ea u thusang?

Ee	1
Chee	2

1

20.15 Haeba ee, u ne u lokisitse le mang?

_____

_____ 2 – 3

20.16 Na o ile a fihla ka nako?

Ee	1
Chee	2

4

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21. **'Me:**
Nakong ea pelehi, na tse latelang li ile tsa etsahala

21.1 Ngoana a hlaha ka santhaho

Ee	1
Chee	2

[ ] 5

21.2 Haeba ee, hlalosa ho ileng ha etsahala?

_____

_____

[ ][ ] 6 – 7

21.3 Na hlooho e ile ea hlaha pele?

Ee	1
Chee	2

[ ] 8

21.4 Haeba chee, ho ile ha hlaha eng pele? hlalosa

_____

_____

[ ][ ] 9 -10

21.5 'mele oa ngoana o ile oa hlaha ka mora hlooho?

Ee	1
Chee	2

[ ] 11

21.6 Haeba chee, Hlooho e ile ea lateloa ke eng?

_____

_____

[ ][ ] 12 - 13

21.7 Malula a ne a fokola?

Ee	1
Chee	2

[ ] 14

21.8 Haeba malula a ne a sa fokole, o lahlehetsoe ke mali a makae? Hlalosa

_____

_____

[ ][ ] 15 – 16

21.9 Thari e ile ea tsoa hang-hang?

Ee	1
Chee	2

[ ] 17

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21.10 Haeba chee Thari e nkile nako ekae ho tsoa?

Metsotso e 30 ngoana a hlhile	1	
Hora ngoana a hlahile	2	
Hora tse 2 ngoana a hlahile	3	
Hora tse 3 ngoana a hlahile	4	
Thari e ile ea salla	5	☐ 18

21.10.1 Na thari e ile ea itsoela ka boeona?

Ee	1	
Chee	2	☐ 19

21.10.2 Haeba chee thari e ile ea thusoa joang ho tsoa? hlalosa

_____

_____ ☐☐ 20 – 21

21.10.3 Ea u thusang o ile a etsang ka thari?

Ea epeloa ke ea thusang	1	
Ea epeloa ke 'me	2	
Ea epeloa ke ea moholo oa lelapa	3	
Ke ba bang _____	4	☐ 22

21.11 Na ho ile ha ba le tlhaka?

Ee	1	
Chee	2	☐ 23

21.11.1 Haeba ee , Na tlhaka e ile ea rokoa?

Ee	1	
Chee	2	☐ 24

21.11.2 Tlhaka e ile ea rokoa ho kae?

_____

_____ ☐☐ 25 – 26

21.12 Ngoana o hlahile a phela?

Ee	1	
Chee	2	☐ 27

21.13 Na ngoana ha a ka a lla ha a qeta ho hlaha?

Ee	1	
Chee	2	☐ 28

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21.13.1 Haeba ee, o ile a thusoa joang hore a lle?

_____

_____ ☐☐ 29 – 30

21.14 Na ngoan o hlahile a le monyebe?

Ee	1
Chee	2

☐ 31

21.14.1 Haeba ee, hoile ha etsoa eng ho mothusa?

_____

_____ ☐☐ 32 – 33

21.14.2 Na ngoana o ile a phela?

Ee	1
Chee	2

☐ 34

21.15 Na mokhujoan o ile oa hlaha pele ho ngoana?

Ee	1
Chee	2

☐ 35

21.15.1 Haeba ee Ea u thusang o ile a etsa eng?

_____

_____ ☐☐ 36 – 37

Ngoana:

22. Na mothusi o ile a hlakola molomo oa ngoana?

Ee	1
Chee	2
Ha ke tsebe	3

☐ 38

23. O ile a hlakola molomo ka eng

Ka molomo oa hae?	1
Ka monoana oa hae?	2
Ka lelapi?	3
Ha ke tsebe	4

☐ 39

24. Ngoan o ile a lla hang ha a qeta ho hlaha?

ee	1
Chee	2
Ha ke tsebe	3

☐ 40

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Hlalosa likarabo tsa haur

_____ ☐☐ 41 – 42

_____

25. Na mothusi o ile a khaola mokhujoana?

Ee	1
Chee	2

☐ 43

25.1 Haeba ee, o ile a o khaola ka eng?

_____ ☐☐ 44 - 45

_____

25.2 Haeba Chee, ho ile ha etsahala eng?

_____ ☐☐ 46 – 47

26. Na mothusi o ile a tlama mokhujoana?

Ee	1
Chee	2
Ha ke tsebe	3

☐ 48

27. Mokhujoan o ile oa tlangoa ka eng

_____ ☐☐ 49 – 50

28. Mokhujoana o ile oa tlotsoa ka eng?

Bolokoe	1	☐ 51
Vaseline	2	☐ 52
Lehlabathe	3	☐ 53
Molora	4	☐ 54
Ha ke tsebe	5	☐ 55

29. Na mothusi o ile a omisa ngoana ha mo hlakola?

Ee	1
Chee	2
Ha ke tsebe	3

☐ 56

30. Na ngoana o ne a futhumetse?

Ee	1
Chee	2
Ha ke tseba	3

☐ 57

31. Hoile ha sebelisoa eng ho boloka ngoan a futhumetse?

Kojoana ea ngoana	1	☐ 58
Kobo ea 'ma	2	☐ 59
Mpeng ea 'me	3	☐ 60
Tseling _____	4	☐ 61

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32. Ngoana o ile a hlahlojoa kae ha a qeta hlaha?

Le ;me	1	
Thoko le 'me	2	
Bakeng tse ling	3	☐ 62

33. Ngoana o ile a noesoa eng pele?

Metsi a hloekileng	1	
Metsi a nang le tsoekere	2	
Lebese la 'ma	3	
Tse ling _____	4	☐ 63

34. O ile a li fuoa neng?

Pakeng tsa hora	1	
Ka morao ho hora	2	
Ka morao ho hora tse tharo	3	
Tse ling _____	4	☐ 64

35. Ngoana o ile a qala ho anya neng?

Hang a hlahila	1	
Ka morao ho hora	2	
Ka morao ho hora tse tharo	3	
Tse ling _____	4	☐ 65

36. Ho ile ha etsahala eng ho oena motsoetsi ka moro ho peleji?

Ka ea hae	1	☐ 66
Ka phomotsoa lapeng	2	☐ 67
Ka tola	3	☐ 68
Ka fuoa lijo	4	☐ 69
Ka ea motebong oa litlhare	5	☐ 70
Tse ling _____	6	☐ 71

37. Na mothusi o ne a itsirelelitse ha a u thusa:

A roetse liatlana	1	☐ 72
A kaoetse matsoho ka lipastic	2	☐ 73
A apere friscoto ea plastic	3	☐ 74
Tse ling _____	4	☐ 75

38. Na hone ho ena le meetlo e neng e sebelisoa nakong ea pelehi?

Ee	1	
Chee	2	☐ 76

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38.1 Hlalosa ka moetlo o neng o sebelisetsoa 'me

_____ 77 – 78
_____ 79 - 80
_____

38.2 Hlalosa moetlo o neng o sebelisetsoa ngoana?

_____
_____ 1 – 4
_____

39. Na o ne o khotsofetse ke pepiso ee?

Ka ho tlala	1
Ka 'moho	2
Ke ne ke sa khotsofala	3

5

39.1 Hlalosa mabakea a hau

_____ 6 -7
_____ 8 – 9
_____ 10 -11
_____

40 Ho pepa hoo ho ile ha u tsamaea joang?

Hantle	1
Mahareng	2
Ha mpe	3
Ha mpe ka ho fetisisa	4

12

41. Na u ile oa utloa u khotsofetse?

Ee	1
Chee	2

13

41.1 Haeba ee :

U khotsofetse hobane u pepetse ka ntle ho motebo	1	14
Hobane pelehi e tsamaile hantle	2	15
Hobene u phetse hantle	3	16
Hobane ngoana o phela hantle	4	17
U khotsofalitsoe ke mothusi	5	18
Tseling _____	6	19

41.2 Heaba chee, hlalosa

_____ 20 – 21
_____

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42. U ile oa ea neng motebong ka mora pelehi?

Tsatsing lona leo	1	
Tsatsing le hlahlamang	2	
Ka morao ho khoeli ngoana a hlahile	3	
Ka moro ho beke tse 6 ngoana a hlahile	4	☐ 22

43. Na molekane oa hau one a nka karolo pelehing:

A emetse ho thusa ka tsa litsietsi	1	☐ 23
A emetse ho bitsa banna ba bang ho mothusa	2	☐ 24
Ho etsa/ ho lata lempara	3	☐ 25
Ho ba teng nakong ea pelehi	4	☐ 26
Ho batla/ ho lefella thuso ea koloi	5	☐ 27
Tse ling _____	6	☐ 28

44. Na molekane oa hau o ne a khotsofalete pelehi ka ntle ho motebo oa litlhare?

Ee	1	
Chee	2	
Ha ke tsebe	3	☐ 29

44.1 Hlalosa

_____

_____

_____ ☐☐ 30-31

☐☐ 32 -33

Rea leboha ha o nkile karolo

ADDENDUM H

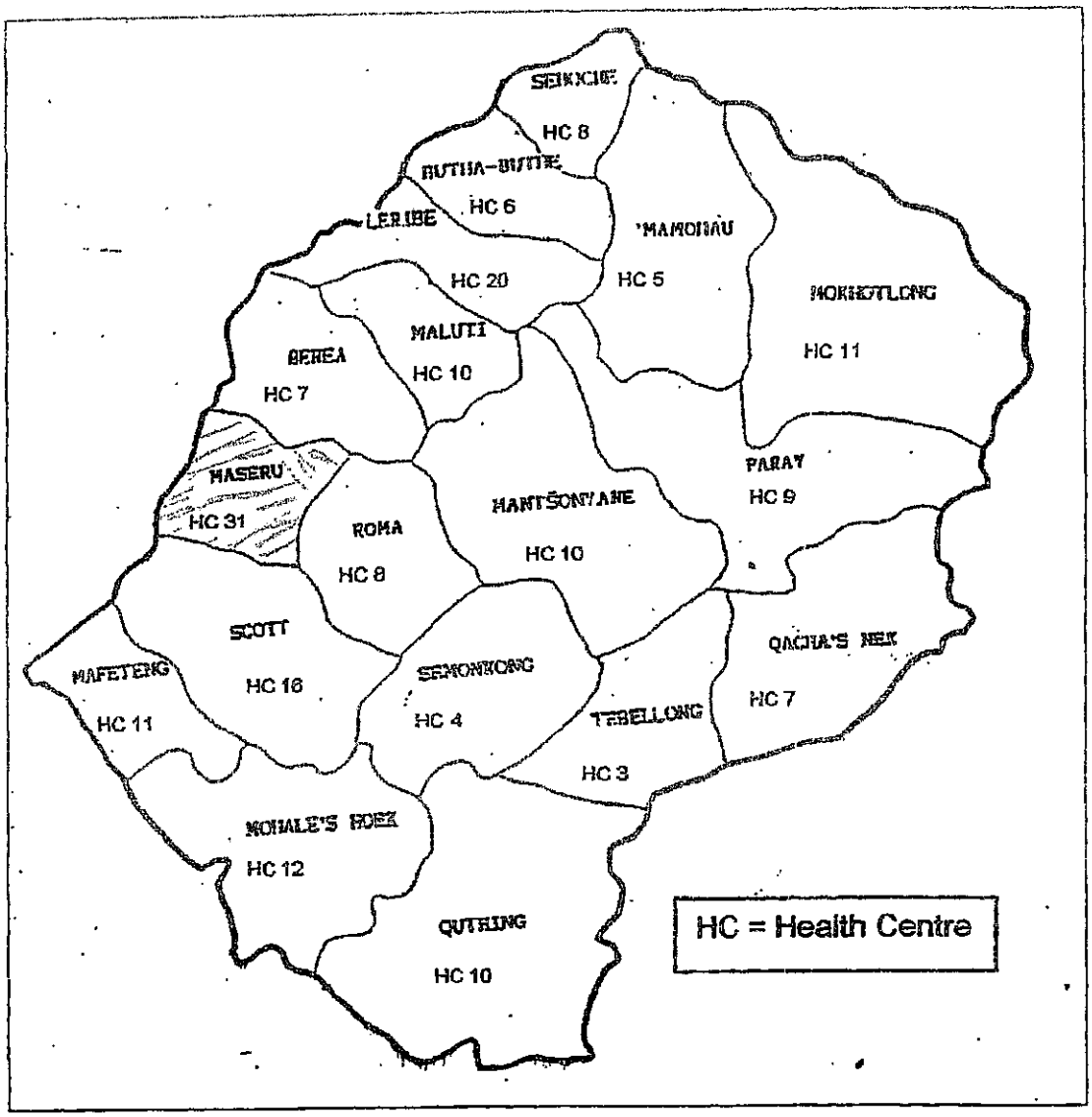

FIGURE 1.1: **Lesotho health service areas** (Source: MOHSW, 2001:1)