STRENGTHENING THE SYSTEM OF CONFIDENTIAL ENQUIRY INTO MATERNAL DEATHS (CEMD) IN LESOTHO

By

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Declaration

I ---------- attest here that this mini dissertation entitled ***"Strengthening the system of Confidential Enquiry into Maternal Deaths (CEMD) in Lesotho"*** is my original work that has not been submitted previously for any other degree at any other University. All sources used and or quoted have been identified in text and acknowledged by means of complete references.

Signed:

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Tlalane Ramaili Letsie Date

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Dedication

This study is dedicated to my late father who had inspired my love for education. I wish you were here "*Mokuena oa 'Mantai*" to see God's completion of what you started.

Rest in peace.

Abstract

The purpose of this study was to describe through Appreciative Inquiry (AI), the strengths, opportunities and aspirations of all stakeholders involved in the Confidential Enquiry into Maternal Deaths (CEMD) system in Lesotho. This was done with an intention of supporting and strengthening the work of this system.

The study was conducted using a qualitative descriptive design and Appreciative Inquiry as a research technique. AI draws from the principle of positivism, where by strengths base, rather than problems are a point of focus to resolve problems.

The researcher was seeking to appreciate the best of what the system is, by discovering its strengths. The participants used their strength base to envision the best of what the system could be. They also drew strategies that will enable them to attain the envisaged future CEMD in Lesotho. Data collection along with primary data analysis was conducted in a one day AI workshop.

The participants for the study were selected using non-probability selection and comprised of representatives of all stakeholders of CEMD in Lesotho. The sample size was 20 participants comprising of four (4) members of QMMH maternal mortality review committee, ten (10) Maternal Mortality Assessors each representing one of the ten districts in Lesotho and six (6) members of the LCCEMD, two of which also represented the MOH.

The results of the study reflected five main themes that portray the strengths of the CEMD system in Lesotho; namely government commitment to CEMD, an effective feedback mechanism, strong communication system, a strong support system following maternal death and Maternal Death Review (MDR) and lastly an effective training and monitoring system. The participants used these strengths as the base to map out an envisaged ideal system of CEMD in five years, which was reflected in a collage form.

The dream phase depicted more government commitment where a revolution against maternal deaths was declared, urging government to commit more resources to CEMD. Interlinks and integration of the efforts of other disciplines in curbing maternal deaths was encouraged. Strengthening communication, Advocacy for MDR and dissemination of key messages about safe motherhood are seen as crucial in

strengthening CEMD in Lesotho. Participants lobbied for support of the carers of the diseased mother as well as those involved in MDR. They recommended a system of trust with an element of debriefing and counseling to avert psychological impact of MDR. Training and monitoring need to be more decentralized for capacity building on both MDR processes and skills acquisition in caring for pregnant mothers.

During the design phase participants realized that with only one year to 2015, the target of reducing maternal deaths by 75 % may not be realized. They however realized that it is possible to prevent primitive maternal deaths; those that are avoidable. They drew a bold affirmative statement “Lesotho amazes the world: Primitive Maternal deaths down to zero by 2015”. A plan to realize this included: strengthening information sharing, improving the infrastructure for Maternal and child health (MCH) services, ensuring availability of Human resources and commodities.

The researcher concluded that with the positive attitude, the stakeholders of CEMD in Lesotho were able to realize the strengths of the system and used them as a platform of improving it. An improved system is likely to yield recommendations that will enable Lesotho to improve maternal health and curb maternal deaths. The study was concluded with recommendations for clinical practice, pre-service and in-service education, research, the LCCEMD, and regulatory bodies for health professions.

Key words: Confidential Enquiries into Maternal Deaths, Maternal Death review, Appreciative Inquiry.

Abstrak

Die doel van hierdie studie was om deur Waarderende Ondersoek (WO) die sterktes, geleenthede en aspirasies van belanghebbendes wat in die Konfidensiële Ondersoeke na Moederlike sterftes (KOMS) sisteem van Lesotho (LKKOMS) betrokke is te beskryf. Hierdie proses is gevolg ten einde die werksaamhede van die sisteem te versterk en te ondersteun.

Die studie is gedoen deur ‘n kwalitatiewe beskrywende ontwerp te gebruik en WO as navorsings tegniek. WO is geskoei op die beginsel van positivisme, waar ‘n sterkte-gebasseerde fokus eerder as problem-gebasseerde fokus gebruik word om probleme op te los.

Die navorser het die beste in die stelsel waardeer deur die sterkpunte te ontdek. Die deelnemers het hul sterkpunte gebruik as basis om die beste van die sisteem te visualiseer. Hulle het ook strategieë uitgewerk wat hul in staat sal stel om die gevisualiseerde toekoms vir die KOMS in Lesotho te bereik. Data insameling en gepaardgaande primêre data analise is gedoen tydens ‘n een-dag WO werkswinkel.

Die resultate van die studie het vyf hoof temas wat die sterk punte van die KOMS sisteem in Lesotho uitbeeld naamlik: regerings toewyding aan KOMS, ‘n effektiewe terugvoer meganisme, sterk kommunikasie sisteem, sterk ondersteunings sisteem na ‘n moederlike sterfte en die moederlike sterfte ondersoek (MSO) en laastens ‘n effektiewe opleidings- en moniterings sisteem. Die deelnemers het hierdie sterk punte gebruik om die gevisualiseerde ideale sisteem vir KOMS in vyf jaar voor te stel as ‘n collage.

‘n Nie-waarskynlikheidsteekproefneming met gerieflikheidsseleksie is gebruik. Die navorsing is gedoen met twintig (20) deelnemers bestaande uit ses (6) lede van die LKKOMS; vier (4) lede van die fasiliteits moederlike sterfte ondersoekspan van die Queen ‘Mamohato Memorial Hospitaal en tien (10) distrik moederlike sterfte assessors.

Die droom fase het meer regerings toewyding uitgebeeld wat die vorm aangeneem het van ‘n verklaring van revolusie teen moederlike sterftes, ‘n bepleiting van die regering om meer hulpbronne aan KOMS te verskaf. Integrasie en skakeling met die

pogings van ander dissiplines om moederlike sterftes in die vermindering van moederlike sterftes is aangemoedig. Versterking van kommunikasie, advokatuur vir MSO en verspreiding van sleutel boodskappe oor veilige moederskap is gesien as van kritiese belang vir die versterking van KOMS in Lesotho. Deelnemers het beding vir ondersteuning van diegene wat die oorlede moeder versorg het, asook diegene betrokke by die MSO. ‘n Sisteem van vertroue, met elemente van ontlading en berading is voorgestel om die negatiewe impak van MSO te verminder. Opleiding en monitering moet gedesentraliseer word om ook kapasiteit te ontwikkel beide in die MSO proses en vaardighede in die sorg van swanger moeders.

Gedurende die ontwerp fase het deelnemers besef dat met slegs een jaar tot 2015, die doelwit van ‘n vermindering van moederlike sterftes met 75% nie haalbaar is nie. Hulle het egter besef dat voorkombare moederlike sterftes(primitiewe sterftes) wel voorkom kan word. Derhalwe is ‘n bevestigende stelling opgestel: ‘Lesotho verbaas die wêreld: primitiewe moederlike sterftes af na nul teen 2015.” ‘n Plan om hierdie doelwit te bereik sluit in deel van inligting, verbetering van infrastruktuur vir moederlike en kinder gesondheidsdienste, beskikbaarheid van menslike hulpbronne en kommoditeite.

Die navorser het ten slotte bevind dat met die positiewe houding, die belanghebbers van die KOMS in Lesotho in staat was om hul sterk punte te identifiseer en dit te gebruik as platform vir die verbetering van die sisteem. ‘n Verbeterde sisteem kan aanbevelings doen wat Lesotho in staat sal stel om moederlik gesondheid te verbeter en moederlike sterftes te verminder.

Die navorser het die studie afgesluit met ‘n evaluasie van die data wat die aanbevelings in die kliniese praktyk; vroedvrou opleiding; navorsing en die LKKOMS ingelig het.

Sleutel woorde: Konfidensiële ondersoek na moederlike sterftes, Moederlike Sterfte Ondersoek, Waarderende Ondersoek.

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List of acronyms

AI	Appreciative Inquiry
AJR	Annual Joint Review
CARMMA	Campaign on Accelerated Reduction of Maternal Mortality in Africa
CEDAW	Committee on Elimination of Discrimination Against Women
CEMD	Confidential Enquiry into Maternal Death
CHAL	Christian Health Association of Lesotho
EMONC	Emergency Obstetric and Neonatal Care*
IDSR	Integrated Disease Surveillance and Response
LCCEMD	Lesotho Committee on Confidential Enquiry into Maternal Death
LMDPC	Lesotho Medical, Dental and Pharmacy Council
LNC	Lesotho Nursing Council
MCA	Millennium Development Account
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MDR	Maternal Death Review
MDAF	Maternal Death Assessor's Form
MDNF	Maternal Death Notification Form
MOH	Ministry of Health
MOHSW	Ministry of Health and Social Welfare
NCCEMD	National Committee on Confidential Enquiry into Maternal Death
NHREC	National Health Research Ethics Committee

NTG	Nominal Group Technique
QEII	Queen Elizabeth II
QMMH	Queen ‘Mamohato Memorial Hospital
UKCEMD	United Kingdom Confidential Enquiry into Maternal Death
UN	United Nations
UNFPA	United Nations Population Fund
WHO	World Health Organization

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CHAPTER 1

OVERVIEW OF THE STUDY

This chapter gives an overview of the study. It is the plan that introduces the study and delineates its background. The background gives a mental picture of what prompted the researcher to undertake this study. This led to the development of the problem statement, purpose and objectives of the study. The research design and research methods are briefly described. The chapter is concluded with the ethical considerations and the value of this study.

1.1 INTRODUCTION

Childbearing is a natural phenomenon that brings with it a profound experience of joy for the mother, the family and the society. This important moment can be clouded by misery if the mother dies during the process. Maternal mortality has been a global concern for many years. Measures have been put in place address it, but there is still a global escalation of maternal mortality (Mesquita and Kismodi, 2012: 79).This is despite the evidence that maternal mortality is avoidable and preventable. The World Health Organization (WHO), in "*Beyond the Numbers*", the seminal manual on maternal deaths (2004), indicated that the main causes of maternal deaths are known. It is further indicated that 99% of these deaths, which occur in developing countries can be prevented using well known interventions (Mesquita and Kismodi, 2012: 79). Egypt has been cited as a country that has attained a significant success in reducing maternal mortality by introducing simple changes in practice, thus improving quality of care for mothers (WHO, 2004: 5).

1.2 BACKGROUND

Pandemic problems such as maternal mortality require a unified global approach in order to be reduced or eradicated. This notion has prompted the member countries of the United Nations (UN) to take a global stand to reduce maternal mortality amongst other global problems in 2000. The Ministers of Health of the UN member states convened at the UN headquarters in New York to adopt the "United Nations Millennium Development Declaration" which incorporates among others Millennium Development Goal (MDG) five *"improving maternal health*", with the goal of reducing maternal mortality by three quarters by the year 2015 (United Nations, 2010: 1).

This was an appropriate move as these political leaders are policy makers and funders of national health services. Their commitment is a crucial building block to attainment of maternal health care strategies.

It is indicated in the0 MDGs progress report (2013: 4) that maternal mortality ratio has decreased by 47 per cent globally. While this would call for celebration, the reality is; the developing countries are far from reaching the target. It is important however to note that there is only one year to the deadline. Lesotho, like many of the African countries south of the Sahara is faced with a tragedy of an escalating maternal mortality.

The process of introducing Maternal Death Reviews (MDR) systematically in all African countries started in 2003, however South Africa had already started in 1997 (South Africa, NCCEMD, 2007: 4). It was said to be the only Sub-Saharan country in 2009 that had incorporated the system of maternal death reviews in its health care system. The system is led by the National Committee on Confidential Enquiries into Maternal Deaths (NCCEMD). The first report in South Africa was published in 1999, called “Saving Mothers’’ and it has been published triennially ever since then (South Africa. NCCEMD, 2007: 4). Lesotho unlike its neighbour, South Africa, only established its NCCEMD in 2009 and has published its first report in 2013.

As indicated above, South Africa has been using a formal system of Confidential Enquiries into Maternal Deaths (CEMD) since 1997. It is in these enquiries where causes as well as factors contributing to maternal death are identified, classified according to the origin and then recommendations for prevention are made.

The Saving Mothers Report for the triennium 2008-2010 revealed that 66.7% of maternal deaths were probably and possibly avoidable (South Africa. NCCEMD, 2010: v). The highest percentage (49.0%) of these avoidable factors was attributed to patient oriented factors such as non-attendance of or infrequent antenatal care, delay in seeking medical help and unsafe abortions. This was followed by administrative factors accounting for 35.2% and health worker related factors which accounted for 22.3%, though they varied at different levels of care (South Africa. NCCEMD, 2010:20).

A similar analysis of maternal deaths in Lesotho would be very helpful in the Health Care System. It can be instrumental in steering Maternal and Child Health Care Services towards prevention of maternal mortality. Policy makers would be aware of avoidable factors specific to their country and allocate more resources towards preventing them.

Prior to the inception of CEMD in Lesotho, Maternal deaths were sporadically reported as part of the Joint Annual Review for the Ministry of Health and Social Welfare (MOHSW), which is currently the Ministry of Health (MOH) since 2012. According to the AJR of 2010, 88% of Christian Health Association of Lesotho (CHAL) facilities reported maternal deaths in 2009, a subtotal of 15 deaths. Seventy percent (70%) of Government health facilities also reported maternal deaths, with Queen Elizabeth II, the referral hospital then reporting a total of 41 deaths. Queen Elizabeth II was closed in September 2011, to be replaced by Queen 'Mamohato Memorial Hospital as a referral hospital. Other government health facilities jointly reported 12 maternal deaths. The subtotal of maternal deaths in government health facilities was 53 (Lesotho. Ministry of Health and Social Welfare, 2010: 77). This brings a total number of maternal deaths in the country in that year to 68. Since there was no formal system of maternal death review, only 14 (20.5%) of these cases of maternal deaths were reviewed. The proportions and percentages could not be computed as there was no indication of total births in that year (Lesotho. Ministry of Health and Social Welfare, 2010: 77). This prompted an establishment of a formal system of maternal death reviews in Lesotho.

1.3 RESEARCH PROBLEM

The problem of maternal mortality in Lesotho is evidently not nearing an end. According to the AJR of 2010, maternal deaths in 2009 accounted for 11% of all deaths of women at child bearing age (15-49). The maternal mortality ratio for Lesotho as reflected in the 2004 demographic survey was 762/100,000 live births. This figure increased to 1435/100,000 live births in the same document of 2009 (Lesotho, Ministry of Health and Social Welfare, 2009: 259). Lesotho released its first report on CEMD in 2013 and it is called "*Polokeho Tharing*". According to this report Maternal mortality ratio for Lesotho as of 2013 is at 1155/100 000 live births, a slight decrease from the 2009 survey but short of the expected 70.5/ 100 000 live births in

2015. The report reflects the primary causes of maternal deaths in order of their magnitude as: haemorrhages (31.7%), hypertension (25%), non- pregnancy related infections, including HIV (11.7%), miscarriage (8.3%) and medical conditions (6.7%) Majority of these deaths (91.6%) were avoidable. Most mothers died in the post partal period (61%) and 78.3% of all maternal deaths occurred from direct causes (Lesotho. Ministry of Health, 2013: 7). This is a clear indication that Lesotho is not moving positively towards attainment of MDG 5 target.

These alarming statistics call for serious intervention. One intervention approach that most countries that are embracing the notion of MDGs are using is an establishment of National Committees on Confidential Enquiry into Maternal Deaths (NCCEMD). These committees serve to compile statistics on maternal deaths, inquire about the causes of such deaths, factors that contributed to them, missed opportunities in the care as well as sub-standard care. They ultimately, following the analysis and collation of data, make recommendations for improving maternal health (De Kock and Van der Walt, 2004: 4-1).

Lesotho is still a neophyte in the use of Confidential Enquiry into Maternal Deaths (CEMD) as a tool to mark up the national status of maternal mortality. A National Committee on Confidential Enquiry into Maternal Deaths (NCCEMD) was incepted in 2009. It was named Lesotho Committee on Confidential Enquiries into Maternal Deaths (LCCEMD). At the time, 36 health care workers were trained on death notification and assessment of maternal deaths. Maternal death reviews only started in January 2010.

The system of CEMD in Lesotho is composed of three structures; facility review teams, district assessors and the LCCEMD. The point of departure for reporting a maternal death is the facility maternal mortality review, which is carried out by the maternal mortality review team of such a facility. Immediately after the death has occurred, the facility must notify the LCCEMD. LCCEMD will issue a unique number to ensure that this case is not reported twice. The facility must discuss the death of this woman within twenty four (24) hours or forty eight (48) hours if it happened at the Health Centre. It is at this level where, after the review, a Maternal Death Notification Form (MDNF) is completed and forwarded together with the patient's file to the LCCEMD. The committee checks completeness of patient's records removes

the name from the file and attaches the unique number. The patient's record is then forwarded to the assessor in another district other than the one where the death occurred. They review the records to identify the primary cause of death, contributing factors, substandard care and missed opportunities. They will then complete a Maternal Death Assessors' Form (MDAF) and sent it to the LCCEMD within thirty days. The LCCEMD will then collate all data from assessors and write a report with recommendations for improvement (Lesotho. Ministry of Health and Social Welfare, 2009: 3).

According to Dr. Nonkosi Tlale, Reproductive Health Technical Advisor and the Chairperson of the LCCEMD, in a conversation held at the Ministry of Health and Social Welfare headquarters on 11 July 2011, the structures of the CEMD at the grassroots level are following the procedure of reporting very well. These are: the Facility Maternal Mortality Review Committees and the Maternal Death Assessors. This is despite the emotional strain and depression that is evoked by assessing the death of a mother. She however indicated that the LCCEMD as the terminal structure has a problem, as members at times are not able to honour the meetings. The quorum for decision making is often not met and a few members that are available often face a mammoth task of collating data. This has brought about delays in the final analysis and compilation of the report.

The seminal manual on maternal death review "Beyond the numbers" shows a number of approaches to maternal death review. Lesotho has selected CEMD. The background and problem statement above clearly reflect that this system is not functioning optimally to attain its purpose, hence a need for intervention. Due to the nature of CEMD, conventional problem solving strategies are not ideal in investigating it. The researcher has therefore decided to use Appreciative Inquiry (AI) for this study. Contrary to problem based strategies, AI is a strength based approach to problem solving.

1.4 RESEARCH QUESTIONS

Following an analysis of the problems of CEMD in Lesotho, the researcher asked the following research questions:

- What are the strengths of CEMD in Lesotho, as identified in an AI process?

- How can the strength-based approach of AI strengthen the CEMD system in Lesotho?

1.5 THE AIM OF THE STUDY

The aim of this study was to:

Describe through AI, the strengths, opportunities, and aspirations of all stakeholders involved in the CEMD system in Lesotho. The intention is to support and strengthen the work of this system and ultimately reduce maternal deaths in Lesotho.

1.6 THE OBJECTIVES OF THE STUDY

The objectives of this study are to:

- Gain entry into the system of CEMD in Lesotho in order to conduct the study
- Organize an AI workshop
- Guide participants to identify the strengths of CEMD in Lesotho
- Guide participants to envision an ideal CEMD for Lesotho
- Guide participant to draw strategies for attaining the envisioned ideal system

1.7 RESEARCH PARADIGM

The researcher used constructivism as a paradigmatic perspective of this study. The philosophical underpinning behind constructivism is the idea that people's thoughts about the world are shaped by their interpretation and construction of the phenomenon rather than simply recording it (Reed, 2007:26). Constructivists assert that knowledge is a product of individual's interaction with their environment and they construct it through meaningful experiences they undergo. They believe knowledge is created by the mind not discovered by it; therefore the researcher tapped on this notion by asking a positive core question, which set participant's minds to create the preferred future of CEMD in Lesotho.

Another perspective held by constructivists is that understanding is driven by participation and conversation and the reality of truth is the negotiation between all parties involved in the research. Constructivism is believed to change both the researcher and the participant in their interaction. This enables their knowledge to be in context and time dependant, thus propelling them to strive for more (Petit and Huault, 2008: 75). The researcher selected this paradigm because of its close

alignment with AI; that of using the strengths base and interaction for improvement of performance.

1.7.1 Ontology

Ontology is described by Botma, Greeff, Mulaudzi and Wright (2010:40) as the philosophy that deals with the nature of reality. It answers questions about the nature and characteristics of the phenomenon under study. It also determines the way forward and decisions to be made by the researcher. The researcher believes the nature, strengths, opportunities and aspiration of each of stakeholders of the CEMD in Lesotho is dependent on the resources available at their disposal. Political and individual member commitment, appropriate communication at all levels of the system, and above all provision of accurate statistics to work with play a pivotal role in the effectiveness of this system. This notion helped the researcher to draw an affirmative topic and affirmative questions which guided the participants through an AI data collection.

1.7.2 Epistemology

Epistemology refers to what is known about the phenomena, that is the truth as held subjectively by individuals or groups and determined by their cultural perspectives. Important in this concept is the realization that truth varies and is subjective (Botma et al, 2010: 40; LoBiondo-Wood & Haber, 2006: 134). Botma et al (2010: 40) further unpacked this concept by describing its focus, which is on the structure of the knowledge/truth, not the content. It also seeks to describe how we can know and explain the phenomena and its principles. Epistemology is well supported by constructivism, which asserts that the way people understand the phenomena is guided by their thoughts. It is not a passive process but an active construct and understanding of such a phenomenon (Savasci and Berlin, 2012: 65).

The epistemological stand or view for this research is that CEMD is an ideal system of improving maternal health in Lesotho; thus preventing maternal mortality. An effective CEMD system is instrumental in preventing maternal deaths through sound recommendations. The United Kingdom is cited as one of the countries that saw the success of this system; curbing maternal mortality ratio from 400 to11/100 000 live births in 1999 (WHO, 2004: 79).

Oladapo, Adetoro, Fakeye, Ekele, Fawole, Abasiattai, Kuti, Tukur, Ande and Dada (2009: 2) emphasize the importance of an effective national data system on maternal deaths. They highlighted that, with an appropriate and functional information system on maternal health indicators, the advocacy power and lobbying for political commitment in Maternal and Child Health (MCH) issues is enhanced. They also indicated that countries need to establish a system that provides specific data about maternal health indicators since population based data such as vital registration of deaths is not specific and is unreliable.

1.7.3 Axiology

Axiology is defined by Borys (2012: 339) as a non-explicit and rarely disclosed system of values that generates and directs diverse orders; including social order. It depicts a sense of worth about something.

As the researcher and a midwife, I hold a sentimental value of childbirth as a natural process, one which should be allowed to take place without any interventions. I also hold in confidence a great value of competency for health professional in MCH unit, as their skill is likely to be a crucial factor in saving both the mother and baby's lives where the process that is expected to be normal goes wrong.

Having been involved in the facility maternal death reviews, I have an experience of how depressing the process is, but also how the learning experiences from these reviews could prevent and save lives of mothers in future. I therefore highly believe that a strong system of CEMD is likely to be a vehicle toward attainment of MDG 5 by 2015. My role in this study is to motivate a positive core value into all members of the CEMD in Lesotho, such that they can recognize their strengths and the potential they have in improving this system.

1.7.4 Methodology

The researcher used AI to describe the strengths, opportunities and aspirations of stakeholders within the system of CEMD in Lesotho, as a strategy to strengthen this system. This was intended to enable them to make evidence based recommendations to improve maternal health in Lesotho.

The theoretical basis of this approach is social constructivism. Social constructivists emphasize the importance of collective approach to learning, whereby all stakeholders have an input in their system. They see learning as a product of activity, contextualization and social interaction. They explain that culture plays an important role in social constructivism and the whole is much more important than its elements (Kundi and Nawaz, 2010: 32). This is the notion that is shared by AI which seeks to combine the strengths of all stakeholders in order to advance strategic opportunities and bring about a positive change. Cooperrider (2012: 106) describes this in his article “the concentration effect of strengths” as a system that brings out the best in human organization through a collective experience in their system. The collective whole is seen when strength touches strength at all angles; internally and externally, from top to bottom and across the whole system of relevant and engaged stakeholders (Cooperrider, 2012: 106). The researcher sought to employ this motivating gestalt (whole) to bring the best out of the stakeholders of CEMD in Lesotho as they aspire for the ideal system.

1.8 RESEARCH DESIGN

The study was conducted using a qualitative descriptive research design. Qualitative research is defined by Burns and Grove (2009: 51) as a systematic but subjective approach at describing life experiences and what gives the life experiences meaning. The focus of qualitative research is on quality of processes and drawing meanings that are not experimentally measured or quantifiable and; it deals with emotions rather than numbers (LoBiondo-Wood and Haber, 2006: 131).

This research method is used when there is a need to understand an experience as those who are experiencing it understand it. It can be used to accumulate evidence where little is known about the particular topic of interest, when studying a new topic or to approach an existing topic from a new angle (Botma et al, 2010: 182). Descriptive designs are defined by Brink, Van der Walt and Van Rensburg (2012: 112) as designs that are used where the researcher wants to depict the picture of the phenomenon as it occurs naturally. He does not attempt to establish the causal-effect relationship. This research design was ideal for this study because the researcher simply sought to describe the strengths of the CEMD system in Lesotho as depicted during the AI process.

1.9 RESEARCH TECHNIQUE

Appreciative Inquiry was used to collect data. The emphasis of AI is on collaboration and participation. It sees change as a journey rather than an event (Coulson, Goldstone, Ntuli and Pillay, 2010: 47). The strengths of all participants in a system are used to inspire a potential in development. This was deemed to be the best choice of a research technique for the CEMD in Lesotho as it has just been incepted. Conventional fault finding approaches would be discouraging to all stakeholders who are still trying to establish themselves in maternal death reviews. Again maternal death reviews are depressing and require one to regroup thinking and channel it towards the positive aspects of this exercise. It represents a shift from traditional problem solving strategies to a more developmental and constructive organisational development (Cooperrider et al, 2008: 2). The aim of AI is "to shift system members' thinking to a more positive and generative consciousness in order to achieve transformational change". It encourages them to speak about their system in a way that generates hopes and ideas for the future. The premise is for the participants to reflect on "the first-order change"; the way things are currently done, and venture into the change that could be brought about by the way people speak and think about themselves as a team; "second-order-change" (Conn, Oandasan, Creede, Jakubovicz and Wilson, 2010: 286).

AI is grounded in a number of principles, constructivism inclusive. The figure below shows some of the principles of AI.

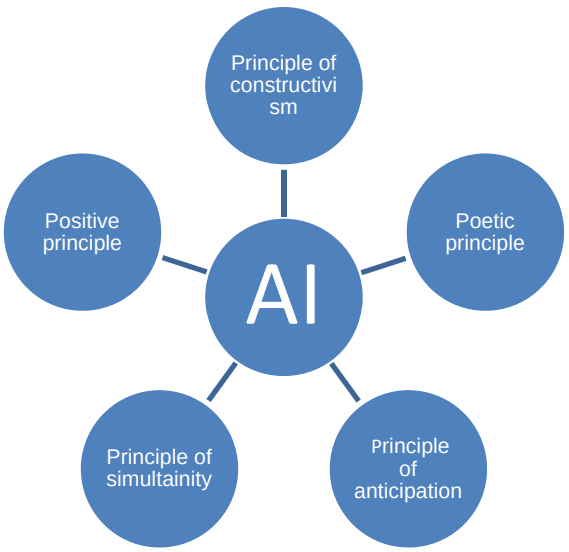

Figure 1: Principles of AI

Source: Adapted from Reed (2007:26)

Constructivism

Constructivist principle asserts that people's thoughts of the world are governed by interpretation and construction. Stories that people tell have the power to shape and reflect the way people think and act (Reed 2007: 26). The researcher sought to capitalize on this principle by encouraging participants to tell stories of the CEMD system that will provoke positive thoughts.

Principle of simultaneity; this principle refers to the inseparable pair of inquiry and change; asserting that in the process of inquiry, people's thinking changes and this ultimately lead to development (Reed, 2007: 26).

Poetic principle; which gives an allowance for participants to present their experiences the way they felt them and choose how they structure them, rather than channelling them through scholarly writing (Reed, 2007: 26).

Anticipatory principle; which refers to people's expectations about the future, which emanates from their thinking about the current stories they tell. If they see the future as full of possibilities, they will work towards attaining such possibilities, conversely if they do not see any hope in future, nothing propels them towards success and they will stagnate (Reed, 2007: 26).

Positive principle whereby positive questions are asked to hold peoples' interest; therefore propel them to invest their energy into positive ideas. At the same time this stimulates their thinking towards the possible best (Reed, 2007: 26).

The interaction the researcher engaged in with the participants in AI was meant to assist them to reflect on their strengths. This enabled them to realize their opportunities and work toward fulfilling their aspirations for an ideal system of CEMD in Lesotho. It was also meant to bring about a positive change, held in notion by both constructivism and AI.

The point of departure in AI process is to identify an affirmative topic. This represents an area of inquiry. It must be phrased affirmatively, not in a problem focussed manner. The purpose of an affirmative topic is to evoke positive discussions about

the desired future. It must be guided by the positive core values such as positivity, curiosity, desire for the future and it must be phrased in bold terms. Selection of a topic may be facilitated by asking the following questions: What is wanted? What is valued? What is most essential to success? (Whitney, 2010: 76).

Once the affirmative topic is in place, then the four phases of AI often referred to as the 4D-cycle; Discovery, Dream, Design and Destiny begin (Cooperrider et al, 2008: 5).

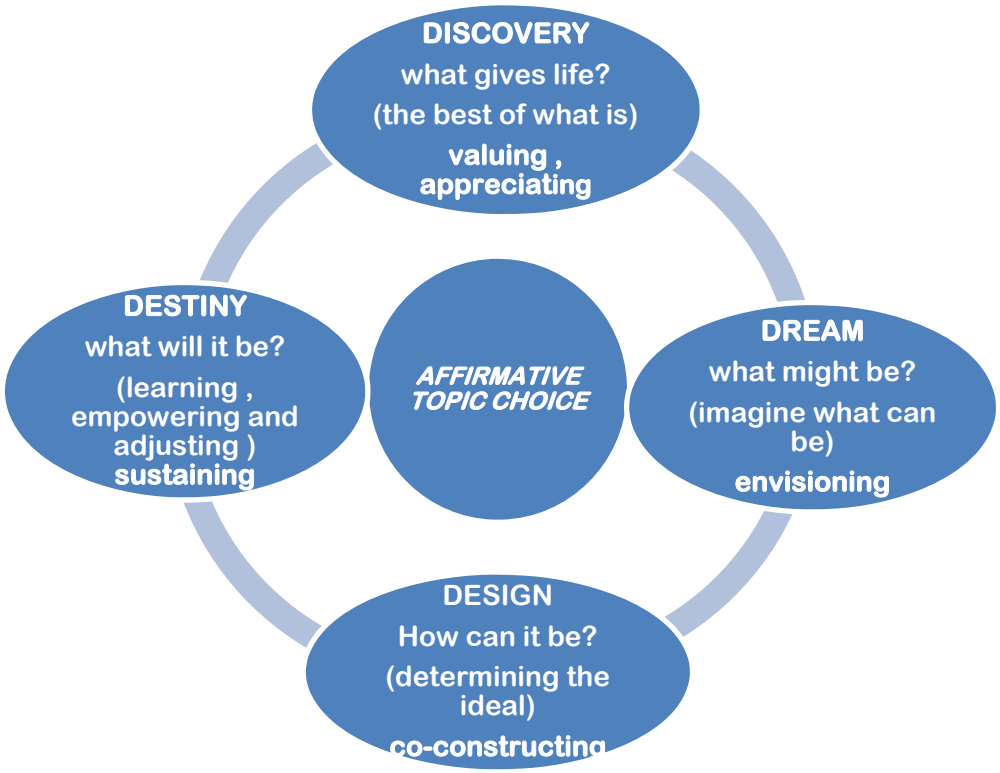

Figure 2: The 4-D cycle of AI

Source: adapted from Cooperrider et al (2008:5)

Discovery phase

This enables participants to value and appreciate things that are positive in their system. It initiates a positive dialogue which even though it starts at an individual appreciation level, will culminate into a collective appreciation thus a shared vision for the organization (Cooperrider et al, 2008: 6). In this phase participants are asked questions that elicit positive discourse. These questions encourage them to relate the most memorable experiences and achievements in the field of focus. The description of these experiences must depict the elements that made them peak experiences (Chapman & Giles, 2009: 298). The discovery is done in pairs whereby

partners ask each other affirmative questions about their past. The pairs' discoveries are then shared with the rest of the group. The common life giving factors that underlie the stories are identified. They are referred to as "the positive core" (Barrett & Ronald, 2008: 56).

The dream phase

This is an innovative phase where the images of the organization's most positive potential, the preferred future, are envisioned. Participants are encouraged to challenge the "status quo" and create possibilities through brainstorming. The minds of participants in this study were provoked to imagine the possibilities of the best CEMD system there could be for Lesotho. They were encouraged to map out in their dream what is happening, who is involved and what role do they see themselves playing in that envisioned future. Even at this stage, the images of the preferred future by participants were shared and a common desired future mapped out (Chapman and Giles, 2009: 298).

Design phase

The phase is referred to by Cooperrider et al (2008: 165) as the social architecture of AI. It involves making positive choices of factors that could make the positive imaginative future a reality. It seeks to transform organizational systems, structures and processes in order to align them to the positive past discovered, at the same time make them amenable to the highest potential dreamt (Cooperrider and Whitney, 2011: Online). The point of departure of this phase is identification of the design elements. This was followed by identification of internal and external relationships that are instrumental in recreating the image of the organization. The design elements and the internal and external relationships were subjected to a dialogue. The participants under the guidance of the facilitator identified themes emerging from the dialogue and drew statements that best support the positive core. These were later transformed into concepts that enabled provocative propositions to be developed. Provocative propositions are statements of possibility that must be stated affirmatively and boldly and be challenging the "status quo" (Cooperrider et al 2008: 165).

Destiny phase

The aim of this terminal phase is to ensure that the shared dream is realized. It demands commitment of individuals and organization to their set aspirations through

the use of their designed blue print (provocative propositions) for realizing the ideal future. This is meant to bring about a lot of changes in the organizational structural, process and structural standards (Cooperrider and Whitney, 2011: Online). It reflects a continuous learning, adjustments and improvisation. Participants were encouraged to draw intended actions that complement the provocative propositions identified at the design phase. Support was solicited from all stakeholders to commit to the provocative statements of their choice as there is no need to approach it in a linear manner, but encourage a volunteering spirit (Cooperrider et al, 2008: 200).

AI is an ideal research technique to use in studying this newly formed CEMD as it is not fault finding. The aim is to encourage all the stakeholders within the CEMD to use a strength to strength base to influence a positive change for this system. The intended results are an effective CEMD and improved maternal and child health.

1.10 POPULATION OF THE STUDY

Population refers to the entire group of persons or objects which are of interest to the researcher. It delineates the boundaries and specifies the inclusion/exclusion criteria (LoBiondo-Wood and Haber 2006: 261). The population for this study was all stakeholders within the system of CEMD in Lesotho. The system of CEMD in Lesotho is made up of four stakeholder groups; namely: Facility Maternal Death Review Committees, District Maternal Death Assessors, Lesotho Committee on Confidential Enquiries into Maternal deaths and the Ministry of Health through Reproductive Health Department.

1.11 SAMPLING

It refers to a portion that is representative of the designated population for the study; therefore replicate the population in characteristics (Brink et al, 2012: 132)**.** A non-probability purposive sampling was used in this study. Non probability sampling infers that not every element of the population has an opportunity to be included in the sample. It requires the researcher to judge and select elements that know most about the phenomenon in question. It provides convenience on the side of the researcher and is more economical. It is more appropriate where the researcher is unable to locate the entire population (Brink, et al 2012: 139). Purposive sampling is a type of non-probability sampling which involves the conscious selection of

participants to include in the study by the researcher because they are knowledgeable about the problem being studied (Brink et al, 2012: 141).

1.11.1 Sample of the study

The sample for this study was all members of the Maternal Mortality review Committee of QMMH Lesotho, District Maternal Mortality Assessors, all members of the LCCEMD, two of which were officers from the Reproductive Health Department of the Ministry of Health. The researcher deliberately selected the maternal mortality review committee of the facility that is best reporting maternal deaths, which is QMMH. This facility, which replaced QEII upon its closure in 2011, is now a referral hospital therefore has a vast experience in the review of maternal deaths and participants would bring this positive experience to the AI workshop. The decision to use the best reporting facility was prompted by the fact that the study is a mini dissertation; therefore the scope cannot accommodate all facilities.

1.11.2 Sample size

The sample size for the study was twenty (20) participants, made up of four (4) members of QMMH Maternal Mortality Review Committee, ten (10) Maternal Death Assessors, each representing one of the ten districts in Lesotho and six (6) members of the LCCEMD, two of whom were playing the dual role of policy makers and committee members by virtue of their jobs within the MOH. AI can be used with individuals as well as both small and large groups depending on the magnitude of the phenomenon under study and significant people required bringing about change (Aldred, 2011: 58). A further study to be done on the whole system of confidential enquiries into maternal deaths in Lesotho would require a larger sample.

1.12 DATA COLLECTION

1.12.1 Data collection technique

An AI Appreciative Inquiry was used to collect data. The affirmative topic was developed. The researcher developed a question involving the positive core to start the process and an experienced facilitator guided the participants through the process of Appreciative Inquiry. The researcher's position in this study was that of an insider as the nature of qualitative studies uses the researcher as an instrument for

data collection. The researcher was also familiar with the system of CEMD, as she has been involved in the activities of maternal and child health and midwifery education at the ministerial level. She is also a member of the facility maternal mortality review committee at her work place. This position made collaboration and negotiation into the setting easier.

This position however, has its own disadvantage as the researcher may take the familiarity of the setting for granted, one element that can compromise the credibility of the study (Reed, 2007:82). This was overcome by the use of a facilitator, who is an AI expert and not familiar with the setting.

The researcher identified a person who enabled her to access the setting due to the country specific organizational culture. Reed (2007:119) describes this person as a facilitator who has an inside information of the phenomenon under study, and can help the researcher access information that may be helpful in developing an AI plan. While Reed (2007: 119) describes this person as a facilitator, for the purpose of differentiating her from the AI facilitator she will be referred to in this study as the anchor. The criterion for selection of the anchor was as follows:

- It was a person who has been working with maternal and reproductive health at the Ministry of Health for five years or more.
- She has been part of the planning for inception of CEMD in Lesotho therefore understands how this system operates
- She has an authorized access to LCCEMD, therefore aware of the whereabouts of all stakeholders.

It is important to note however that anchoring can infringe on ethical principles if it is done by a person who holds authority over participants. They may find themselves coerced into participating in the study; hence they may not meaningfully contribute to this process of inquiry (Reed, 2007: 120). This was overcome by excluding the anchor from the AI process once the researcher had gained entry into the system.

1.12.2 Data collection procedure

Following approval of the research proposal by the appropriate structures of the University of Free State and by the National Health Research Ethics Committee (NHREC) of the Ministry of Health Lesotho; the researcher personally sends

invitations to the prospective participants, along with the detailed explanation of the purpose of the study.

Data collection took place in one day. Participants were convened in a conference hall and guided through the AI process using an AI protocol

1.13 TRUSTWORTHINESS

This concept, which is often used interchangeably with validity, more so in quantitative studies, is difficult to measure in qualitative research. Burns & Grove (2009: 383) attribute this to the fact that qualitative researchers often work alone, as is the case in this study, and biases in their work often go undetected. Qualitative researchers however must strive to attain trustworthiness in their studies. They must question an immediate feeling that their conclusions are correct without subjecting them to scrutiny, the concept referred to as holistic fallacy. The criteria that is used to judge trustworthiness in qualitative studies are credibility, transformability/transferability, dependability and confirmability.

LoBiondo-Wood & Haber (2006: 168) describe credibility as the “truth of findings as judged by the participants and others within the discipline”. Transformability deals with whether or not the study findings can be applied to other similar contexts. Dependability explores whether the findings can be applied over a period of time while confirmability is concerned with the bias of the researcher (Brink et al, 2012: 127). The researcher ensured trustworthiness of this study by subjecting the positive core question as well as data themes that emerged during data collection to experts in the field of study, which is midwifery, as well as expertise in Appreciative Inquiry. The researcher also used literature review to control the results and further assessed transferability of the results to other settings by comparing the work of other scholars in the phenomenon being studied.

The fact that participants collaborated in both data collection and data analysis during report back sessions also assured credibility of the study results. The nature of data collection in AI, which is an open discussion and consensus, also ensures trustworthiness of the study. The research has an opportunity to observe non-verbal communication during feedback sessions. She was able to note with interest the different opinions during discussions till participants reach consensus.

1.14 ETHICAL ASPECTS

Ethical issues in research are meant to protect both the researcher and the participants. The researcher is spared the impact of litigation where research has infringed on the rights of participants. The participants are protected from harm and their rights are spared. Ethical issues that were considered in this study were based on three fundamental principles; namely principles of respect for persons, beneficence and justice (Brink et al, 2012: 34).

1.14.1 Respect for persons

1.14.1.1 Protection of human rights

Human rights are the claims and demands that are either justified by individuals or groups. They are meant to preserve people's self respect, dignity and health (Burns and Grove, 2009: 189). Researchers need to protect human rights of participants by adressing the following areas:

Self determination

This emanates from the principle of respect for persons by recognizing their autonomy. Individuals with diminished autonomy, who may not fit fully the criterion for informed consent, such as children and the mentally ill will need additional protection (Brink et al, 2012: 35). The reseacher ensured participants' self determination by explaining the purpose of the study and allowing them to decide voluntarily whether they participate or not. They were also informed of their right to withdraw from the study anytime without penalty.

Right to privacy

The notion of privacy relates to protection of private information that the participants give to the researcher from being divulged to others who are not part of the research team. Privacy of the participants in this study was ensured as there was no need for private information. The participants were sharing a common positive core question (Burns and Grove,2009: 194).

Right to anonymity and confidentiality

This right links well with the right to privacy, as it demands that there should be no link between data collected and the identity of the participants. Confidentiality requires that private information shared by the participant be managed by the researcher in such a manner that it cannot be accessed by people outside the scope of research. If such data is to be shared, the participant's consent must be sought. (Burns and Grove, 2009: 196).

Issues of anonymity and confidentiality in AI research are rather controversial as AI studies are public or shared amongst participants. Again the setting may be clearly identifiable making confidentiality difficult or almost impossible. Participants have to work together, thus maintaining anonymity was impossible. This problem was overcome by the concept of ownership; consent may be obtained for data that is personal and that of the group (Reed, 2007: 122). Data collection in this study however did not require personal information that is not related to the participant's work in the committee, therefore confidentiality was protected by group ownership. Data collected was kept locked so that it may not be accessed by people who are not involved in the study; either as participants or researchers thus confidentiality was ensured. The participants were however made aware before giving consent that once the study is complete the information will be shared on academic platforms. When this happens, they will not be referred to as individuals but as groups.

1.14.2 Justice.

Right to fair treatment

The basis of a fair treatment in research is the principle of justice. It mandates researchers to select participants for objective reasons that are of benefit to the study. This protects participants who may be deemed unfavourable from being subjected to harm. It also dissuades the researcher from using participants whom he wants to benefit from the study as a personal favour (Burns and Grove, 2009: 198).

The study did not carry any risks and this was explained to the participants. Their selection to participate in this study was purposive as they are knowledgeable about activities within the CEMD system.

1.14.3 Beneficence

Right to protection from discomfort and harm

This right emanates from the principle of beneficence, that one should do good and above all do no harm (Burns and Grove, 2009: 198). DeVos, Strydom, Fouche and Delport (2011: 115) assert that participants may not only be harmed physically but may experience emotional harm. They further indicated that emotional harm may not be easily predicted compared to physical harm, but it has more detrimental consequences for the participant. Researchers are expected to evaluate the risk-benefit ratio of their studies, minimize the risks or otherwise abandon the study if risks outweigh the benefits. Researchers are also mandated to inform participants at hand about any minimal risks. This will give them an opportunity to determine whether they participate or not. The study did not carry any risks for the participants. The results of the study are intended to benefit participants as an effective CEMD will lighten their workload, while at the same time they will receive an emotional benefit brought about by safety of both mothers and babies in their care.

1.14.4 Measures to protects human rights

1.14.4.1 Consent and informed consent

Consent is defined by Burns and Grove (2009: 201) as an agreement to participate in a study. It is referred to as informed consent when an agreement is made following receipt and comprehension of essential information about the study.

The researcher must disclose the following information to prospective participant in his study: introduction of research activities, description of risks and benefits, assurence of confidentiality, compensation for participation in reseach if any, offer to respond to participants' questions, option for withdrawal and a non-coersive disclaimer (Burns and Grove, 2009: 202). It is important to ascertain the participants' competency to give consent as they need to understand the information and weigh the benefits against risks (Brink et al, 2012: 35). The participants in this study were all within the capacity to consent. They were given all the necessary information about the study and requested to sign a consent form (Annexure E) that was attached to the information leaflet (Annexure D) depicting the details of the study.

1.14.4.2 Review boards

Institutional and departmental approval of the research project

Brink et al (2012:45) describe the role of ethics review boards as a protective mechanism for both the researcher and the participants. These boards hold a legitimate right to refuse permission to conduct the study or they may recommend changes on some parts of the study. These would happen if they are not satisfied that the study is in accordance with the scientific and ethical guidelines.

The researcher submitted the proposal to the evaluation committee of the School of Nursing at the University of Free State. Following approval by this committee the proposal was submitted to the Ethics Committee of the Faculty of Health Sciences at the University of Free State for ethical review (see Annexure A). Approval of the study by this committe served as a precursor for the researcher to request an approval to conduct this study from the National Health Research Ethics Committee Lesotho, based at the Ministry of Health (Annexure B). The letter of approval, along with the request to conduct the study, study protocol, information leaflet and consent form were forwarded to the Chairperson of LCCEMD for permission to conduct the study within the CEMD system.

1.15 DATA ANALYSIS

Data analysis in AI studies may co-exist with data collection (Lapan and Quartaroli, 2009: 289). An inductive data analysis was used for this study. This kind of analysis infers that general statements are drawn from specific aspects of data without any pre-determined framework to refer to. It is used when the phenomenon under study is not known or little is known about it (Elo and Kyngäs, 2007: 109). Primary data analysis was done along data collection as the emerging themes were identified throughout the phases of a 4-D cycle. The emerging themes were then given codes. Consensus about the emerging themes was reached by voting on the ideas. The strategy draws some similarities between AI and Nominal Group Technique. Data was then interpreted, whereby validated data was fitted into a frame of reference that gives it meaning. The researcher was able to relate validated themes with what comprise good practice. During the design phase of AI, the researcher together with

the participants drew a plan of action and identified strategies that will enable the participants to realize the envisaged ideal system of CEMD in Lesotho.

1.16 VALUE OF THE STUDY

AI is both a research technique and an intervention; therefore it will enable the participants to realize their strengths and aspirations, which will benefit the whole system of CEMD

The results of the study will enable the stakeholders of the CEMD to build on the identified strengths in order to achieve the aspirations of this committee. This will result in an effective CEMD system.

An effective CEMD will improve maternal health through its recommendations, thus women at child bearing age will benefit from improved and quality health services.

An improvement in Maternal and Child Health services will benefit the communities. The lives of mothers and babies will be saved.

The use of recommendations made by a strong CEMD system will help reduce maternal mortality. The country through the Ministry of Health will be able to attain MDG 5, target 5.1, which is reduction of maternal mortality by three quarters by the year 2015.

1.17 CONCLUSION

While this chapter outlined the general plan for the study the next chapter will map out the methods that were used to conduct this study.

CHAPTER 2

RESEARCH METHODOLOGY

2.1 INTRODUCTION

The first chapter dealt with the research plan for this study. This chapter explains concepts and outlines the methods that were used in conducting the study. The process of maternal death review is discussed. Appreciative Inquiry as a research method is introduced and the process outlined as it unfolded on the day of data collection.

2.2 CONCEPTS

2.2.1 Maternal death review

Maternal death reviews are a form of an audit in which factors that led to a maternal death are identified and measures to prevent them in future are delineated. A number of methods can be used to review maternal deaths, however CEMD has been identified as the method that has a potential of making the greatest impact on the largest number of women's lives. These enquiries consider all or a representative sample of a specific region and draw up both clinical and service recommendations to prevent tragic deaths of mothers at child bearing age (WHO, 2004: 22).

2.3 THE VALUE OF CEMD

Confidential Enquiries into Maternal Deaths is a valuable tool that enables countries to achieve good health care outcomes for mothers at procreation. This is made possible by appropriate implementation of recommendations drawn during the process of CEMD. This system does not draw value in manipulating numbers nor questioning the accuracy of reporting when maternal deaths are high but lies in the following factors:

- It is not a fault finding system but seeks to identify avoidable factors and areas of deficiencies in an effort to prevent them from recurring.
- Confidentiality nature of this system enables the health carers of the mother who died to disclose with confidence all information that will enable the assessors to identify what went wrong and make appropriate

recommendations without fear of punitive measures being taken over them. This is contrary to what used to happen in the past where such Enquiries were conducted for punitive measures (Drife, 2012: 32). Confidentiality is attained by removing the name of the mother and those of the carers before the analysis is done.

- CEMD occurs at the *level of policy making;* therefore the results and recommendations can have a wider impact on maternal health. This level enhances ownership of results and recommendations hence the importance of including the officials from the Ministry of Health in this study (WHO, 2004: 77).
- Confidential Enquiries are dependent on *participation and commitment* of several stakeholders in order for the process to be successful. These stakeholders include policy makers, health professionals and professional organizations (WHO, 2004: 77). The LCCEMD consists of the Obstetrician, Midwife, Anaesthesiologist, Pathologist, Epidemiologist, Statistician, Public health representative, a Medical Officer, Representatives of Schools of Nursing and Representatives of Non-Governmental Organizations (Lesotho Ministry of Health and Social Welfare, 2010: i).
- The process of Enquiry requires stringent supportive strategies for implementation; *hence a crucial role that policy makers play in this system*. It is important that regional and national government are clear about what CEMD is all about. It is not introduced to displace the existing surveillance systems nor its confidential nature meant to excuse misconducts. Policy makers usually want to see quick results, their understanding that CEMD is not a quick fix to reduction of maternal deaths, but seeks to ascertain what led to a maternal death is important. This is referred to as "*faces behind numbers*" (WHO, 2004: 5). It is also highly imperative to make sure that CEMD is not introduced by external agencies or professional organizations without approval of the highest level of government as this can retard its progress. This notion is supported by Mesquita and Kismodi (2012: 79) who assert that even though the governments can outsource the MCH services, they remain directly accountable for the outcomes of such services. The same situation occurred in Lesotho, where UNFPA initiated and supported the CEMD system but enlisted the buy in from the MOH. The MOH endorsed this action and

housed the secretariat of LCCEMD within the Family Health Division of the Ministry of Health. However this does not necessarily signify full accountability for the CEMD system by the MOH. There is a need to draw a sustainability plan for this system beyond UNFPA support.

2.4 THE PROCESS OF REPORTING A MATERNAL DEATH IN LESOTHO

The first step in reporting maternal death in Lesotho is to notify the LCCEMD secretariat of a death using a phone number provided. A unique number will be issued and shall be used in place of the mother's name throughout the process. The facility must then hold a maternal mortality meeting within 24 hours and fill a Maternal Death Notification Form (MDNF) within seven days. This form along with a copy of the mother's records is send to the LCCEMD secretariat at the MOH. The package, with an inclusion of the assessor's form will be send to the assessor, who will analyse the MDNF and the patient's records, fill the assessor's form and return them to the secretariat within 30 days of receipt. The LCCEMD will analyse and collate data of all deaths reported and write the report. Once the report has been written all basic data will be destroyed and the cycle starts again (Lesotho, Ministry of Health and Social Welfare, 2010: 5). All the stakeholders identified in the process of reporting maternal deaths as above formed part of the participants in this study.

The preceding paragraphs introduced familiar concepts and processes in a maternal death review. The next paragraphs are going to outline the methods that were used to conduct the study.

2.5 METHODOLOGY

The methodology entails an outline of the research design, technique, population, sample and data collection procedure for this study.

2.5.1 Research design

The study was conducted using a qualitative descriptive research design. Qualitative research is defined by Burns & Grove (2009: 51) as a systematic but subjective approach at describing life experiences and what gives the life experiences meaning. The focus of qualitative research is on quality of processes and drawing meanings that are not experimentally measured or quantifiable and; it deals with emotions rather than numbers (LoBiondo-Wood & Haber, 2006: 131).

2.5.2 Research technique

The researcher used Appreciative Inquiry (AI) to describe the strengths, opportunities and aspirations of stakeholders within the system of CEMD in Lesotho, as a strategy to strengthen this system. This was intended to enable the stakeholders to make recommendations based on research to improve maternal health in Lesotho.

The emphasis of AI is on collaboration and participation. It sees change as a journey rather than an event (Coulson, Goldstone, Ntuli and Pillay, 2010: 47). The strengths of all participants in a system are used to inspire a potential in development. It represents a shift from traditional problem solving strategies to a more developmental and constructive organisational development (Cooperrider et al, 2008: 2). The aim of AI is "to shift system members' thinking to a more positive and generative consciousness in order to achieve transformational change". It encourages them to speak about their system in a way that generates hopes and ideas for the future. The premise is for the participants to reflect on *the first-order change*; the way things are currently done, and venture into the change that could be brought about by the way people speak and think about themselves as a team; *second-order-change* (Conn et al, 2010: 286).

2.5.3 Population of the study

Population refers to the entire group of persons or objects which are of interest to the researcher. It delineates the boundaries and specifies the inclusion/exclusion criteria (LoBiondo-Wood and Haber, 2006: 261). The population for this study was all stakeholders within the system of CEMD in Lesotho. The system of CEMD in Lesotho comprises of four stakeholders; namely: Facility Maternal Death Review Committees, District Maternal Death Assessors, Lesotho Committee on Confidential Enquiries into Maternal deaths and the Ministry of Health through Reproductive Health Department.

2.5.4 Sampling

Sampling refers to a portion that is representative of the designated population for the study; therefore replicates the population in characteristics (Brink, et al, 2012: 132)**.** A non-probability purposive sampling was used in this study. The participants were conveniently selected because of their knowledge of the system of CEMD and their experience in conducting Maternal Death Review. These stakeholders are already known and their experiences were deemed instrumental in inspiring the ideal system of CEMD in Lesotho.

2.5.4.1 Sample

The sample for this study was made up of members of the Maternal Mortality review Committee of Queen 'Mamohato Memorial Hospital (QMMH) Lesotho, District Maternal Mortality Assessors, members of the LCCEMD. While the policy makers were held up by their responsibilities and could not attend the workshop, There were however two members of the LCCEMD who were playing dual roles of committee members and policy makers. This was brought about by their technical positions within the MOH and in particular reproductive health department, which were putting them at level of policy making; therefore the buy in was not compromised. The researcher deliberately selected the maternal mortality review committee of the facility that is best reporting maternal deaths, which is Queen 'Mamohato Memorial Hospital. This facility is a referral hospital therefore has a vast experience in the review of maternal deaths.

2.5.4.2 Sample size

The sample size for the study was twenty (20) participants. The participants were made up of four (4) members of QMMH Maternal Mortality Review Committee, ten (10) Maternal Mortality Assessors each representing one of the ten districts in Lesotho and six (6) members of the LCCEMD, two of which also represented the MOH. This size is regarded as optimal and ideal as AI can be used with individuals as well as both small and large groups depending on the magnitude of the phenomenon under study and the significant people required to bring about a change (Aldred, 2011: 58).

2.5.5 Data collection

2.5.5.1 Data collection technique

An Appreciative Inquiry was used to collect data. An affirmative topic was identified as; *"Our extra-ordinary system of Confidential Enquiry into Maternal Deaths: an appreciation of the strengths of all stakeholders of CEMD in Lesotho*". The researcher developed an AI protocol (Annexure F) involving the positive core questions to start the process and the facilitator guided the participants through the process of Appreciative Inquiry. The researcher's position in this study was that of an insider as the nature of qualitative studies uses the researcher as an instrument for data collection. The researcher was also familiar with the system of CEMD, as she has been involved in the activities of maternal and child health and midwifery education at ministerial level. She is also a member of the facility maternal mortality review committee at her work place. This position made collaboration and negotiation into the setting easier. The position however, has its own disadvantage as the researcher may take the familiarity of the setting for granted, one element that can compromise the credibility of the study (Reed, 2007: 82).

The researcher gained entry into the setting through an anchor who has been part of the planning for inception of CEMD in Lesotho and therefore understands how this system operates. The stakeholders of CEMD in Lesotho are employed in various health institutions, both Government, private or faith-based. It was therefore not easy for me as the researcher to access them. The anchor put into place all processes that enabled them to convene for the workshop.

2.5.5.2 Data collection procedure

Following approval of the research proposal by the appropriate structures of the University of Free State, and by the National Health Research Ethics Committee of the Ministry of Health, Lesotho, the researcher and the facilitator had two meetings in preparation for data collection. The facilitator was used in this study because the researcher was exploring AI as a research method for the first time and it was crucial to have an expert in this field to oversee the process and confirm its authenticity. The facilitator was also in a good position to oversee credibility of the processes in an

objective manner as he was not familiar with the setting and MDR processes; hence ensuring trustworthiness of the results.

The researcher in collaboration with the Family Health Division of the MOH solicited availability of participants through telephone calls and personal contact for six weeks; explaining the purpose of the study and requesting their participation. Twenty participants responded positively and ultimately attended the workshop on the set date. Two of the participants were officials of the MOH from the Reproductive Health Department, though they were playing a dual role of being committee members and policy makers. Data collection took place in one day. Participants were convened in a conference hall of 'Melesi Lodge, Thaba-Bosiu, Lesotho on the 23rd of September 2013.

The proceedings of the day started with welcoming remarks and an overview of the purpose of gathering by the researcher. She further explained the purpose of the study, distributed information leaflets and consent forms. All twenty participants consented to participate. She introduced the AI facilitator to the participants; who in turn briefed the participants on AI as a research method.

The point of departure in AI process is to identify an affirmative topic. This represents an area of inquiry. The topic was identified as "*Our extra-ordinary Confidential Enquiries into Maternal Death: An appreciation of the strengths of all stakeholders of CEMD in Lesotho".*

The process of AI was explained to participants by the facilitator and he introduced a data collection protocol and explained how it works. The AI facilitator guided the participants through each phase of AI.

The discovery phase started immediately after the explanations. The session was given two hours. Participants were divided into five groups comprising of four people. They then formed pairs within the groups; thus each group had two pairs. The pairs were guided to discover the current strengths and successes of the CEMD; appreciating the best of what is using the AI protocol as a guide. They asked each other positive questions that related to their experiences in working within the system of CEMD and noted the responses in the space provided on the data collection.

The participants shared with each other the peak experience or high point of their work in the CEMD. They indicated what within them or this system inspired this experience. They were also guided to tell what they appreciated most about the system of CEMD in Lesotho and what they valued most about themselves as members. They then indicated to each other the one thing they believed gives life to CEMD system, without which this system would not be the same.

The questions that followed in the AI protocol were meant to invite the extraordinary of the CEMD system. Each participant reflected on the best activity in his/her area of work in the CEMD such as being a maternal death assessor or computation of the result. They narrated the stories about the time when the team was most successful and what they appreciated about their team. They also outlined what is being done to make them feel they are an important part of this system.

While the participants were working in various aspects of CEMD, they still needed to appreciate the system as a whole. They were asked to indicate what they appreciated most about other stakeholders of the system. They also reflected what they saw as unique about CEMD, what is exists within this system to make them feel relaxed, secure and most cherished. They shared the highlight of their work in CEMD and identified the best attributes of the system which they appreciated most.

The session culminated in identifying the three big desires they have for this system. They then summarized the discovery phase by indicating six best stories they extracted from the interview.

After tea break the pairs were reconvened into their initial groups. Group members shared and discussed their experiences. Each participant selected two stories that he/she saw as the best and they were summarized on the flip chart. Each group, comprising of four people ultimately had eight success stories. This exercise is tantamount to the first two phases of nominal group technique; generating ideas and round robin. Each group presented their choices to the rest of the participants and explained why they saw each of those stories as the best; thus mimicking the third phase of NGT; clarification of items. This would enable participants to make informed decisions in the next step of voting for the best stories.

These success stories mapped out the initial themes. The participants then voted for five themes that best represented the core of CEMD in Lesotho, using eight stickers per person. Participants were free to vote for a theme more than once if they believed it was important. The stickers were counted and five themes that represent the positive core of CEMD in Lesotho were depicted.

The participants were then guided through the dream phase; envisioning the preferred future of CEMD in Lesotho. This was an innovative phase where the images of the organization's most positive potential, the preferred future, are envisioned. Participants were encouraged to challenge the "status quo" and create possibilities through brainstorming. Using a set of questions as reflected in the AI protocol, they were asked to envision the positive image of the preferred/ideal system of CEMD in Lesotho in five years. Participants were to depict in this dream of the ideal system, what they see as marvellous about it, what has changed, who brought about the change and how they contributed in that change.

The groups then present their ideal system in a collage form, a picture presentation. They cut out from magazines, pictures that best explained the selected themes, posted them on the flip chart in a manner that delineated how they interrelated to form the whole (gestalt) of their ideal system. The groups then reconvened to share their ideal visions. The participants then identified common elements of their visions and group them together. Opportunities and change ideas reflected in each group were depicted, leading to identification of additional themes. The design phase then followed. Participants were guided to draw a single statement of possibility (provocative statement) for the ideal CEMD in Lesotho This statement was phrased in affirmative bold terms. They then constructed a social architecture for the ideal CEMD; these are desired frameworks and resources that would enable them to realize the opportunities identified in the dream phase and turn the imaginary ideal system of CEMD into reality.

The last phase of AI followed, which is destiny. In reality this phase is more of an action research but need to be planned for in this forum. It delineated the intended actions to operationalize the themes identified in the discovery phase; thus enabling the strengthening the CEMD system in Lesotho. Support was being solicited from all stakeholders. The plans to implement the provocative proposition as well as

strategies for sustainability were drawn. Participants voluntarily aligned themselves with their propositional statement and pledged their commitment to its realization. The day's sessions were evaluated, closing remarks done and the gathering adjourned.

2.6 CONCLUSION

Data collection and data analysis in AI co-exist; therefore the researcher used all data that emerged throughout the 4-D AI cycle to write the report of research findings. The results were compared with the literature during report writing.

CHAPTER 3

EMERGING DATA AND DATA ANALYSIS

3.1 INTRODUCTION

This chapter outlines the results of the study that were depicted during data collection and primary data analysis, which occurred concurrently. An inductive data analysis was used whereby participants drew general themes from the responses given during data collection as outlined in the AI protocol. The chapter is structured to describe the results in each phase of the 4-D AI cycle. The first phase had fourteen questions, list of three desires and a summary sheet. Individual questions in this phase were analysed and the responses summarized in the summary sheet. Each group selected eight stories that best reflected its idea of the strengths of CEMD in Lesotho. These were put into the basket of generated ideas for NGT. A consensus between all participants was reached later by voting on the ideas by use attaching stickers.

Throughout the process of data collection and analysis, emotionality was dominant and was reflected mostly where participants did not understand why they had to have positive thoughts about CEMD while they are reviewing maternal deaths, a factor that is depressing in itself. They indicated that initially they were assessing maternal deaths individually, but were later put into a group in the form of a workshop as they were not coping emotionally and psychologically. This element of emotionality was very helpful as it enabled them later to draw measures to be put in place in an envisaged system in order to address emotional and psychological aspects of maternal death review.

3.2 DISCOVERY PHASE

There were fourteen questions that participants had to ask each other in this phase. The responses for all participants were put together and similar responses grouped such that they reflected all participants' responses not those of individuals. Responses were not put in any order of priority as they were gathered from diverse groups.

Question 1

Tell me about a peak experience, or high point, in your work within the CEMD? A time that you felt alive, most engaged, or really proud of what you did.

- Fourteen (14) participants related the experience of being called on board to serve in an area of CEMD. They indicated that they were proud of being part of the founding processes, where all structures were laid out and defined. Study tours to South Africa were undertaken and they were part of such an experience.
- Another memorable experience, which reflected a mark of LCCEMD members given the nature of activities that were outlined in this experience was; collation of data and putting together the first CEMD report. They were proud of the fact that they are individually acknowledged in the report. This culminated in the preparation for and an actual dissemination of this report to health professionals, they were happy that they had been part of it.
- The other two experiences that also reflected the LCCEMD secretariat were an incorporation of the CEMD into the Integrated Disease Surveillance and Response (IDSR) and the moment of endorsement of CEMD by the government, where LCCEMD was assigned to the Reproductive Health Unit of the MOH.
- At the level of the Facility, participants were happy with the moment of conducting Facility based reviews and they were proud of the guiding role they played following their training in CEMD.

Question 2

What was it about you, the situation, and/or the system of CEMD that inspired this peak experience to emerge? What did you learn from this experience?

The following were cited as the factors that inspired the experiences in question 1:

- Eagerness to learn about what causes maternal deaths in Lesotho and what age groups are affected.
- Some were inspired by the technical positions they were holding which enabled them to support maternal and child health services and prevention of maternal deaths seemed the right thing to do.

- The system itself was cited as an inspiration enough because of its non-fault finding nature, encouraging team spirit where neophyte professional are learning from the experienced ones.
- The response of parliamentarians during the CARMMA launch was also inspirational and encouraged the stakeholders to work even harder.
- The lessons learned from these experiences were:
    - Awareness that with the right systems in place, reduction of maternal deaths can be realized.
    - Team work inspires individual confidence.
    - The CEMD system instils professional responsibility.
    - That linking own role to reduction of maternal deaths inspires one to work even harder in MDR.

Question 3

What do you appreciate most about Confidential Enquiries into Maternal Deaths?

Participants appreciated the CEMD system because:

- It is non-judgemental and not fault finding.
- Its ability to engage participants in an open discussion about the woman's death.
- Enables critiquing of all angles that led to a maternal death thus a learning experience that prevents similar mistakes from being repeated.
- Confidentiality nature of the maternal death reviews.
- A team approach.
- Recommendations generated by this system, if implemented well are likely to improve MCH services and prevent maternal deaths.

Question 4

What do you value most about yourself as a member of the CEMD? What excellence do you bring into the CEMD?

Participants valued and brought into CEMD:

- Their competency.
- Ability to learn.
- Commitment.

- Professional inputs.
- Others brought the knowledge of how the system works and their willingness to work in MDR without an incentive.
- Passion for MCH services and being change agents to colleagues following their training in MDR.

Question 5

What is the one thing that gives life to Confidential Enquiries into Maternal Deaths, without which this system would just not be the same?

Participants cited the following as elements that give CEMD in Lesotho life:

- Team work, respect for confidentiality.
- A non-judgemental approach, commitment of stakeholders.
- The secretariat and.
- Elements that give CEMD in Lesotho life.

Question 6

Tell me about the best [facility maternal mortality review/ maternal death assessment/ computation of maternal death results] you have attended. What was it about that session that made it so effective?*

Given the fact that groups had to choose their area of work, responses were grouped into these areas:

Facility maternal mortality review

- There were two clusters; one was about the disagreement about what was the final cause of death that was to be put in the maternal death notification form. What made the case successful in this regard were the skills of the chairperson of the team.
- Another one was where the referring facility was invited by the facility that received a patient, where she died. They discussed together this particular death. It was a success because the referring facility had a learning experience of what they could have done right and would not let the same experience that led to the woman's death occur again.

Assessors

The assessors delineated the group assessments where for the first time they sat together and analysed the death as the best assessment they had in CEMD. What made it effective was the fact that they were a multidisciplinary team and they were drawing from each other's knowledge and experience. They were able to solicit each other's support when the exercise became stressful.

The LCCEMD

There were two best activities reflected by this group:

- Data analysis and collation where participants fed data into computers and it generated results. What made it effective was the fact that they had shared chapters and they appreciated the contribution of information technology in their work.
- The second one was the release and dissemination of the first CEMD report in June 2013. It was effective because committee members shared the responsibilities, both in preparation of the meeting and in presentations.

Question 7

Tell me about a case where the team successfully [reviewed/assessed/computed the results] in a positive way. What did you do right? Be specific*

- The facility review team cited their success as an extra effort of assessing not only maternal deaths but near misses in their facility. The near misses are described as the severe end of morbidity spectrum in maternal health problems. They are a useful outcome measure for evaluation and improvement of maternal health services (WHO, 2004: 103). What they did right was to control discussions such that they were not blaming, particularly because the mothers were still identifiable.
- The assessors were successful in group assessments and this is so because they exchanged the cases to be discussed. Their success also emanated from the fact that they were able to acknowledge gaps in knowledge of their work, stopped and sought guidance. Team spirit also contributed to their success.

- The LCCEMD was successful in collating data and releasing the report. Team approach and good communication were what they did right.

Question 8

What do you appreciate most about the members of your team?

A number of elements that were not directed to any group emanated from this question and they were as follows:

- Cooperation.
- Support.
- Professionalism.
- Team spirit.
- Commitment.
- Inquisitive attitude.
- Non-judgemental attitude.
- Eagerness to learn.
- A sense of humour.

Question 9

What is done to make them feel that they are an important part of the of the CEMD system?

The team appreciated that they:

- Were periodically congratulated and praised for their efforts and good work.
- Received trainings and were made part of the study tour to South Africa.
- Are given responsibilities.
- Are provided with an enabling environment of open discussions in their work.
- Their inputs are taken seriously.
- They were given feedback of the reviews before it was disseminated to the public.

Question 10

What do you appreciate most about the other stakeholders of the CEMD system? [Facility Maternal Mortality Review Teams, Maternal Death, Assessors, LCCEMD, Policy makers (MOH)]

- The stakeholders appreciated each other for commitment and volunteering spirit to work in the CEMD system, for sharing responsibilities and a team approach in resolving problems.
- They specifically appreciated the LCCEMD for its role in support and provision of logistics, involving everybody in the completion of the report, its firmness in decision making which brought about changes and the motivation and on-going education.

Question 11

Tell me what you do when you feel highly relaxed, most secure, or most cherished in your work? –when it is simply great to be together.

Individuals cited different activities though they were inclined toward the following:

- They feel highly energized therefore perform at the peak.
- Become confident and can work independently.
- Become excited therefore excel at work.
- Meditate and pray.
- Become playful and humorous.

Question 12

What makes the CEMD so unique and exceptional? What do you see as the unique qualities of this system?

The system was cited as unique because of its respect for confidentiality, safeguarding maternal and child health interests, its commitment to reduction of maternal mortality, team spirit, a non-fault finding attitude and sensitivity in dealing with maternal death review, which is seen in its confidential nature.

Question 13

Share the highlight of your work in the CEMD – a time when you have felt most effective and when your contribution meant most to you and the people around you.

- The facility review team cited the first maternal death review they held immediately after receiving training on CEMD and how to report maternal death.
- The assessors indicated group assessments as the highlight of their work where they assessed many deaths in a short period. They recalled very well the support they received from LCCEMD at that time and indicated their appreciation.

The LCCEMD had two highlights:

- Supporting the whole process of CEMD from inception and overseeing it through to compilation of the report and its dissemination.
- They indicated that they were overwhelmed by the reaction of the health professionals at the dissemination meeting.

Question 14

What do you regard to be the best aspect or attribute of the CEMD; the aspect or attribute you appreciate most?

The following were identified as the best aspects of CEMD:

- Confidentiality.
- The recommendations toward improving maternal and child health thus reduction of maternal mortality.
- Accountability for most if not all maternal deaths that occur at the facilities.
- Team work.
- It is an eye opener to monitoring and evaluation of MCH services.
- The non-judgemental nature.

It became apparent from the responses in this phase that data collected about the strengths of CEMD in Lesotho has a value orientation. Some values were system oriented while others were participant oriented, all complementing each other to make out the strengths of CEMD system.

Figure 1 below depicts the values that are the strengths of the CEMD in Lesotho.

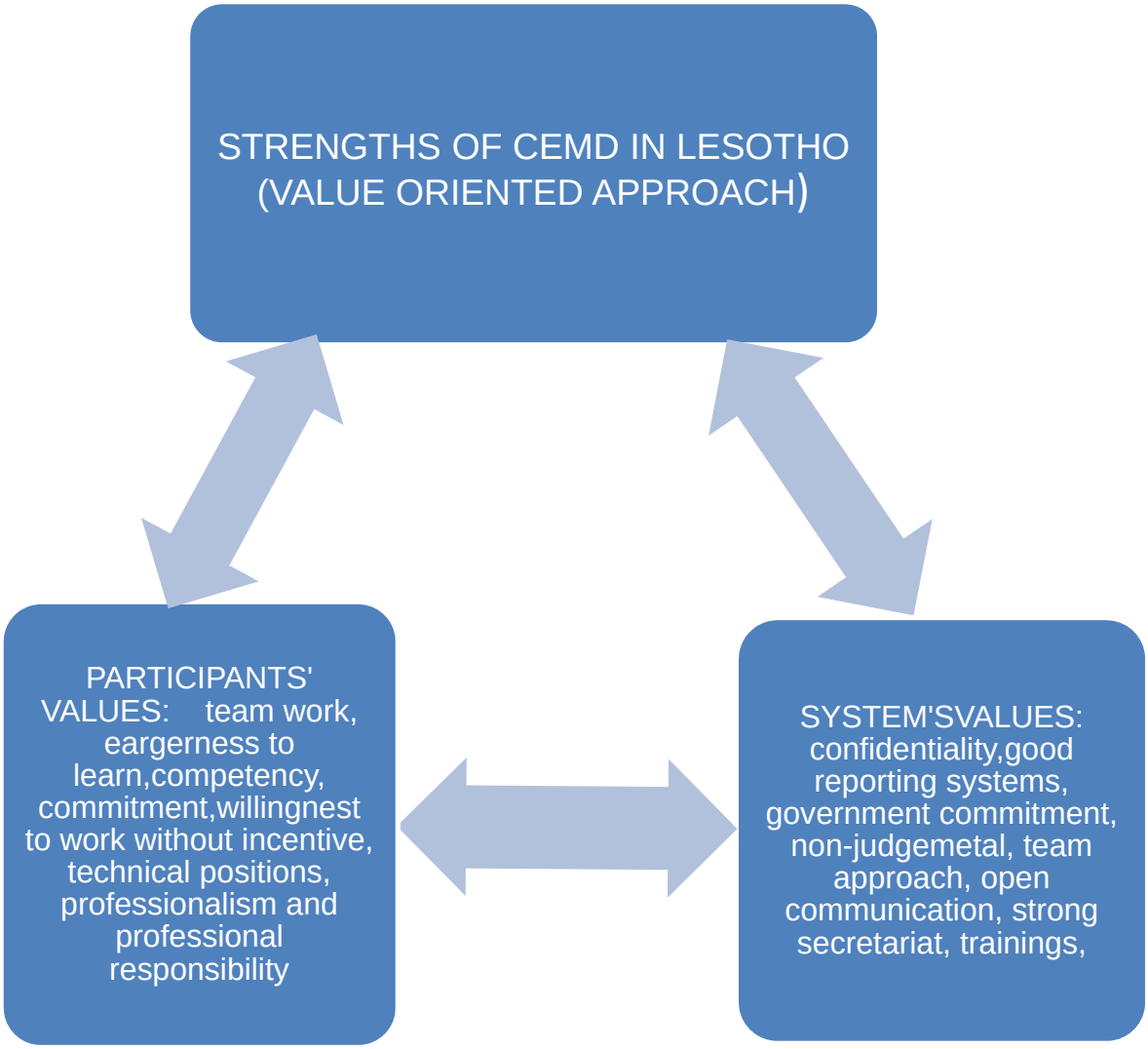

Figure 3: CEMD VALUE ORIENTED STRENGTHS

I compared the values that emerged from the data with the summaries drawn by participants at the end of this phase and found out that they bear similarities. This was helpful because it created a verification ground for participants to select the two value -oriented statements that they assume are representative of what they believe to be the strengths of the CEMD system from their summaries and put them in the basket of ideas for NGT. This resulted in eight statements per group and ultimately forty for all participants. The results were as follow:

Table 1: GROUP IDEAS OF A STRONG CEMD SYSTEM

Group 1	Group 2	Group 3	Group 4	Group 5
Community understanding of the CEMD system	Praising of CEMD members when they have performed	Community participation	The Ministry of Health accepted and adopted the CEMD in Lesotho	The acceptance of the CEMD in Lesotho by the MOH
Importance of support of facilities by LCCEMD	Because of firmness of the CEMD members, all recommendations are carried out well	Meetings for assessors are scheduled	Confidentiality of the enquiries	The nature of the LCCEMD secretariat which is believed to be giving CEMD a life
The LCCEMD was also responsible for trainings on EMOC	CARMMA launch and government commitment	Availability of obstetricians at all facilities	Professionalism	The results of the enquiries were openly discussed at the national level
Confidentiality	The fact that the Committee is not meant to punish but is for corrective measures	Direct communication between LCCEMD secretariat and the assessor	Team work	Maternal death assessments were done in a group
Respect of rules, regulations and procedures of CEMD	Team work of CEMD members results in success of the committee	Written policies governing CEMD be known to all	Feedback was given in all directions	Confidentiality and anonymity
Importance of an enabling environment during maternal death assessments	Training of CEMD members on EMOC	Training of all doctors and midwives	All stakeholders engaged in situational analysis	Scientific approach to review of maternal deaths
Timely release of the report is important	Implementation of CEMD recommendations on maternal death MDS at facility level	Feedback to all facilities	The MOH identifying the current gaps and finding means to redress them	Technical support and experience by LCCEMD
When appreciated one becomes energized and performs at his/her level best	Support, by LCCEMD to mentor, monitor and evaluation	Meetings for assessors are scheduled	MOH trained Trainers for EMOC and MDR	Relaxation where members took fellowship

The last step of the discovery phase was meant for participants to reach consensus on five themes that best represent the positive core of the system of CEMD in Lesotho. This was done through a nominal group technique. Participants already had a pool of ideas generated from the summaries. Each one of those ideas was clarified during a presentation thus enabling participants to make an informed choice during voting. Each participant was given eight stickers to vote with. They were allowed to vote for a theme they highly believe in as many times as they want. The following emerged to be the themes that best represent the strengths of CEMD in Lesotho:

Government commitment to the system of CEMD was highly appreciated with thirty-two (32) votes.

It was followed by importance of feedback, which in this system was reported to be given in all directions and at all levels, receiving thirty –one (31) votes.

Communication via the secretariat was voted third with twenty-eight (28) votes.

Appreciating, praising and relaxation of the stakeholders were rated forth and received nineteen (19) votes.

Training and monitoring followed with ten (10) votes.

The rest of the themes received between one and four votes, therefore the five themes noted above were deemed to be strengths of the CEMD system in Lesotho.

3.3 DREAM PHASE

3.3.1 Analysis of collage

The participants then engaged in a dream exercise. This was done in the form of a collage, the visual image of an extra ordinary system of CEMD in Lesotho. All groups used images cut from magazines to map out their extraordinary system of CEMD using the five themes identified in the discovery phase. They explained the interrelationship of these themes to make a whole, using pictures.

The collage for each group was described and ultimately the themes that emerged from all of them were described narratively.

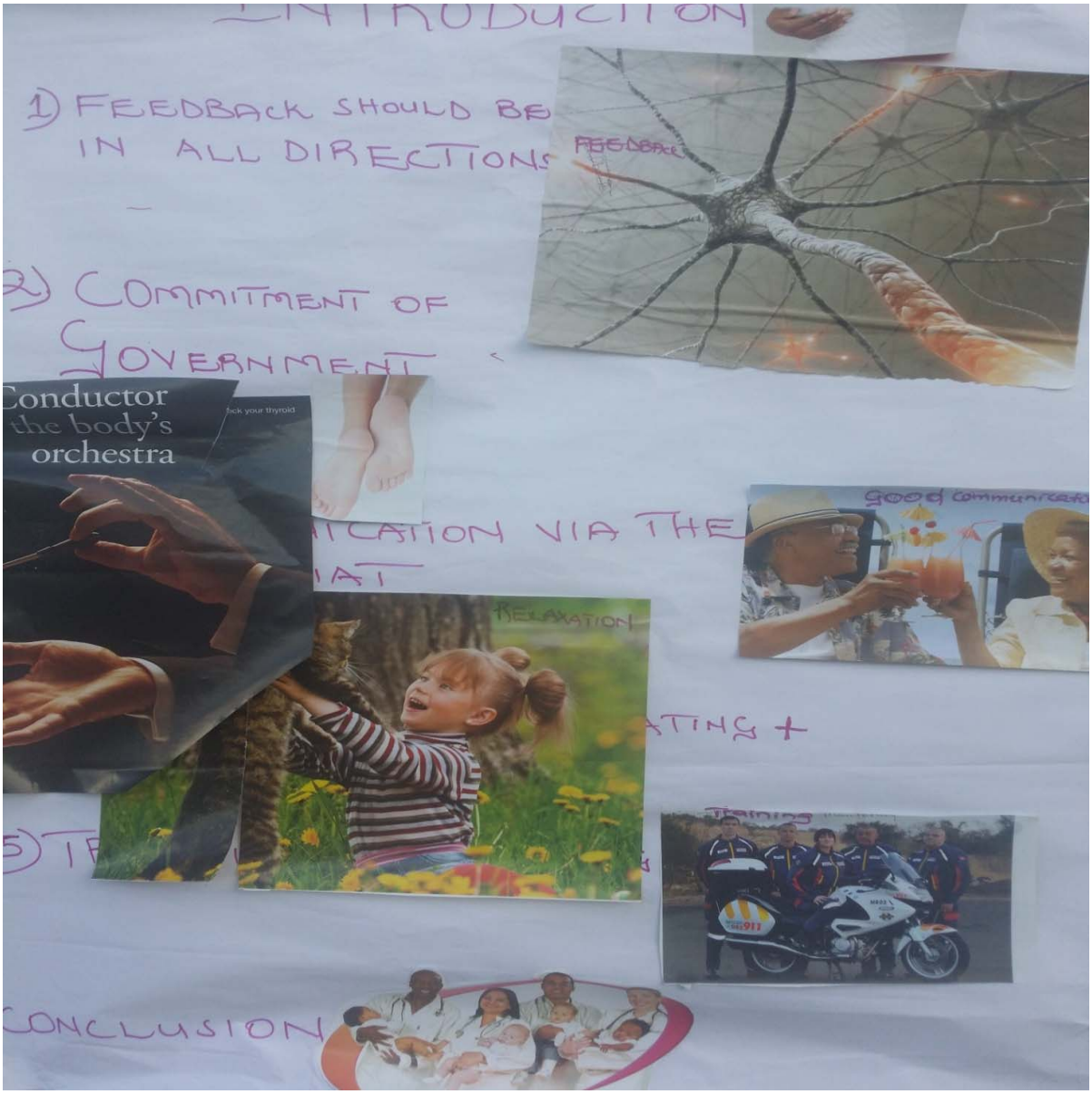

Figure 4: Group 1 Collage

The group described elements as a synergy and they complement each other to make the whole of the envisaged ideal system of CEMD. They indicated a need for a sound communication system to disseminate feedback in all directions and at all levels, represented by a neuron. The government however has to take bold steps, represented by the feet on the picture to steer all the processes and show commitment to CEMD. The government is also seen as a conductor that is supposed to harmonise the song of safe motherhood. They indicated also a need for training similar to the training on riding motorbikes. Training is therefore seen as a vehicle for driving the process of CEMD. When all is done, expectation is healthy mothers and babies and for the health team to relax.

Figure 5: Group 2 Collage

The group saw the point of departure for a strong CEMD in Lesotho as an appreciation of the availability of this system and praising the LCCEMD for putting it in place. They acknowledged the need for ongoing training that can be done in the form of workshops in advanced clinical care and guidelines on safe motherhood. Best weapon for trainings were cited as healthy brains and commitment to enable implementation of what is learned. A two way communication; to and from the secretariat was cited as crucial to CEMD. Policies and feedback from the secretariat are transmitted to all stakeholders, while the stakeholders avail information about maternal deaths and reviews to the secretariat through communication.

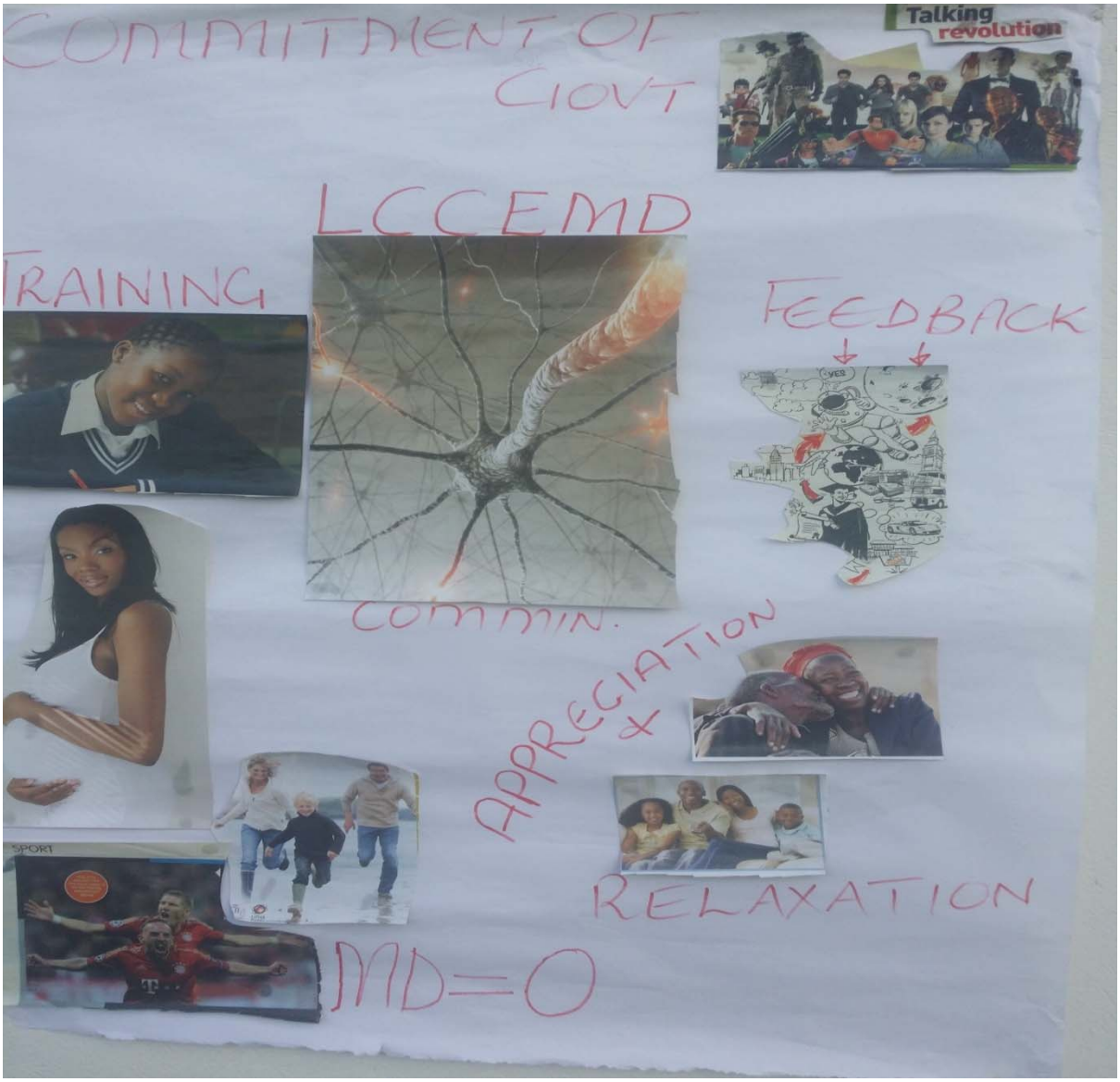

Figure 6: Group 3 Collage

This group summarised it all in one sentence " *With the government commitment that we have, we are talking revolution here, we are saying in five years' time, maternal deaths will be equal to zero".*

They intend to achieve this through strong links between the LCCEMD and the government as well as undertaking training of doctors, midwives and assessors. Upon receiving a positive feedback, there is a need for praise and appreciation of the LCCEMD. The group extended with this collage their declaration of zero maternal deaths by 2015.

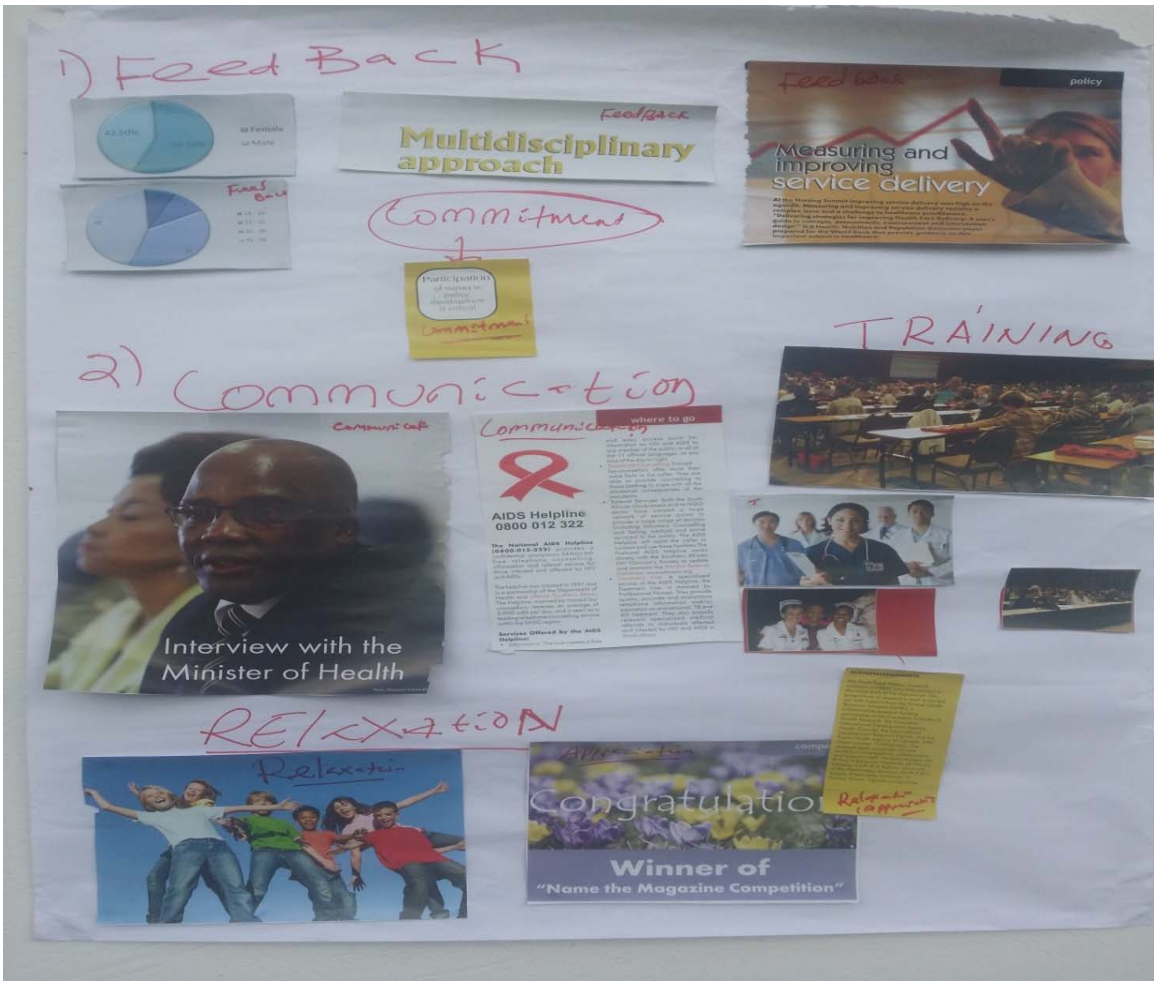

Figure 7: Group 4 Collage

The group has identified feedback as a starting point for a strong CEMD as information regarding the status of MCH indicators will prompt the stakeholders to react. They cited the 91.6% avoidable causes of maternal death from the CEMD report as an indicator that will put stakeholders on their toes and enable them to react. They believe that feedback is actually part of monitoring where service delivery is measured and improved. They interlinked *feedback with communication* whereby policy makers communicate policies to the grassroots, depicted in the picture by an interview with the Minister of Health. They also believe that for sustainability, there is a need for continuous training on CEMD so that they introduce young blood into the system, depicted by a picture of a classroom and newly trained nurses and doctors. When all is done well and maternal death ratio is down, then the LCCEMD needs to congratulate stakeholders because they are winners. Everybody will then relax.

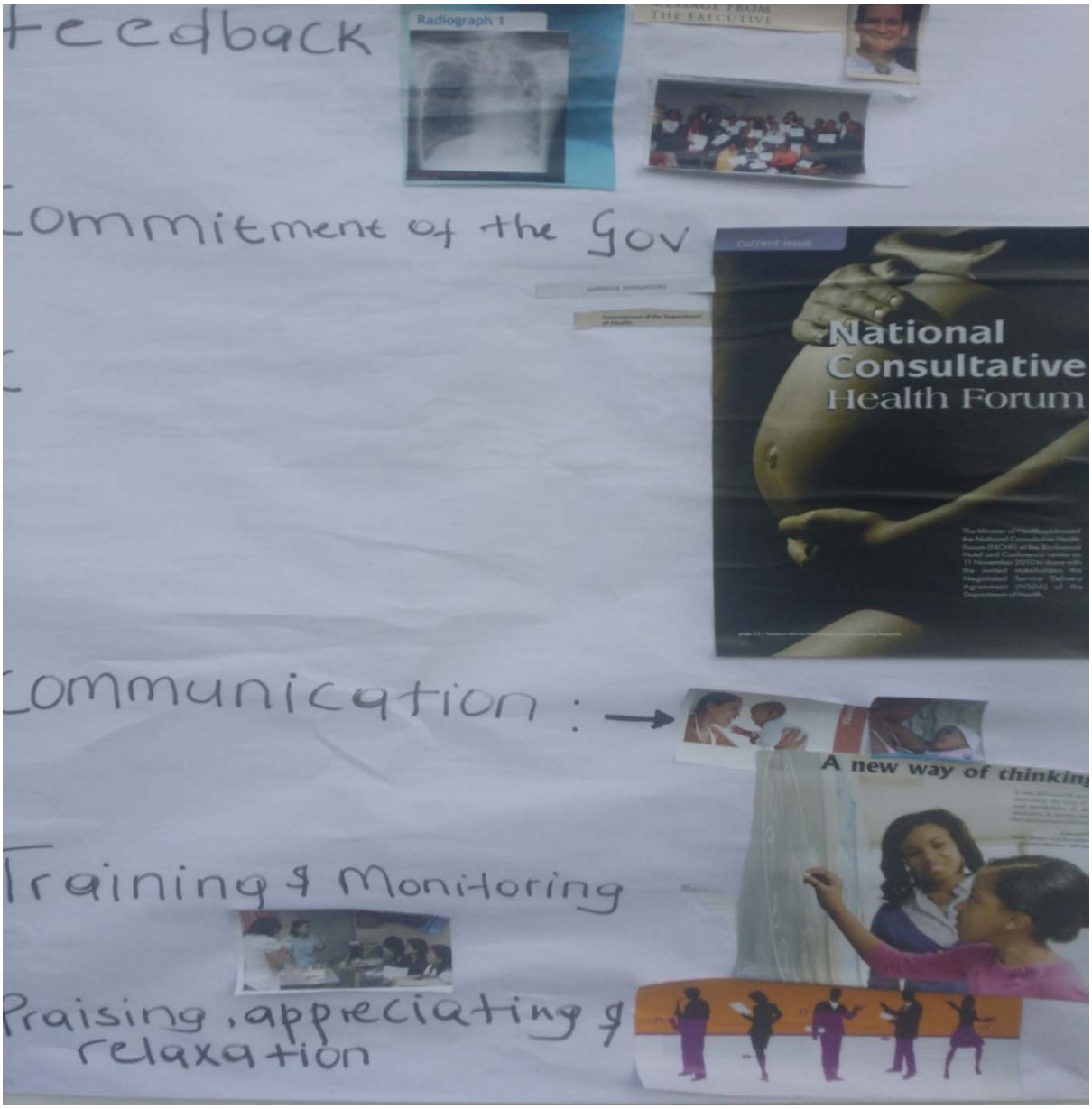

Figure 8: Group 5

The picture of the letter from the executive depicts the inter-link between feedback and communication. The two require a multidisciplinary approach which could be achieved through national consultative health fora on maternal and child health issues. Trainings were cited as an element that inspires a new way of thinking and leads to change, therefore would be instrumental in improving the CEMD in Lesotho.

The group believes encouragement in the form of praising would show appreciation to the stakeholders, thus an improvement to the system.

3.3.2 Thematic analysis

Each group reflected five main themes in their collage. These were analysed in the form of descriptive narratives**.** The way different groups described similar themes differently though working toward the whole of CEMD was exhilarating. Similar pictures were used in different themes and their descriptions fitted well in that theme. These were common descriptions for each theme:

3.3.2.1 Theme 1 -Government commitment to CEMD

This theme was portrayed as an analogy of revolution in war. They believed the same way governments commit to weaponry in protecting the civil servants in war zones is the same way they should commit resources to the fight against maternal deaths; thus capacity building of the CEMD system in Lesotho. This revolution is described as taking the power back and standing the ground against the death of mothers during procreation. The government of Lesotho was cited to be showing serious commitment to CEMD by engaging fully one of its partners UNFPA to oversee funding of most CEMD activities through the LCCEMD, while other partners also incooperated maternal and child health issues in their work plans.

Government commitment to CEMD was also seen as a conductor of the body's orchestra, without which the whole body would lose its function. The government commits to CEMD through the LCCEMD secretariat at the MOHSW. This structure is seen as a point of departure for all CEMD activities. This commitment was also depicted where the MOHSW would engage all stakeholders to participate, not only in assessing maternal deaths but also in sharing the results and disseminating the recommendations to the larger community of health care providers. This notion of government commitment was shared by three groups.

3.3.2.2 Theme 2 -Feedback in all directions

This has been identified as the second strength area of the CEMD in Lesotho, thus the second theme. It was described through the image of a neuron which carries messages to and from the brain to the whole body. CEMD was described as a well-functioning neuron as messages are relayed well from the facilities that are doing maternal death reviews, through to the assessors and ultimately to the LCCEMD for collation of data. The results are communicated back to the facilities through

stakeholders' dissemination meetings. The inter-link of the neuron's dendrites signifies the integration of all stakeholders of CEMD. The LCCEMD is seen as a hub for all activities of CEMD in the country. The use of statistics as feedback in maternal death reviews was deemed crucial by participants as graphic presentations are easier to understand and comprehend.

3.3.2.3 Theme 3 - Communication

Communication was cited by the participants as very crucial in the operations of CEMD in Lesotho LCCEMD is regarded as the point of departure as well as recipient of all communication within the system of CEMD. Participants however emphasized the importance of supportive messages from the key political figures such as the Ministers. This has significantly been portrayed in the form of messages from magazine editors and interview with the Minister of Health, South Africa. Participants believe health workers need to disseminate key messages about safe motherhood, either verbally, written or in mass media. Communication and feedback are said to be intertwined and cannot be separated as feedback is a form of communication.

3.3.2.4 Theme 4 - Appreciation, praising and relaxation

Dealing with maternal death reviews is a rather tedious and depressing activity. It requires tremendous support from the policy makers as well as the LCCEMD secretariat. Participants indicated that they felt strong when they were appreciated for the work they are doing by the LCCEMD secretariat. They were appreciated by the chairperson of the committee and received praises for all their achievements. This enabled them to relax in their work despite its magnitude and depressing nature.

3.3.2.5 Theme 5 - Training and Monitoring

This theme was highly regarded by the participants as they indicated that, training and follow up for both the processes in CEMD and best practices in maternal and child health were necessary for the CEMD in Lesotho to be successful. This task was well done by the CEMD, which decentralized trainings on how to report a maternal death and the Emergency Obstetric and Neonatal Care (EMONC) trainings. Participants reported to have received a tremendous technical support from the LCCEMD, particularly in the areas of mentoring, monitoring and evaluation of the

use of tools geared at providing appropriate mother and child health services; thus reducing maternal death. These tools include but not limited to Lesotho Obstetric Record, which houses all documentation for the care of the mother from pregnancy to puerperium. Training and monitoring were depicted in the collage in various ways; which all described the importance of knowledge in caring for procreating families.

The most important question was who were targeted in these trainings and what was their significance? The EMONC trainings were targeted for midwives and doctors, while specific trainings on the processes of maternal death review were given to all personnel working in MCH units, Maternal Death Assessors and LCCEMD members.

3.4 DESIGN PHASE

The dream phase, described in collage had mapped out the ideal system of CEMD for Lesotho. It had identified five (5) building blocks (themes) for this system, who is involved in the processes of building; government, midwives, doctors, facility review teams, maternal death assessors, development partners and LCCEMD. The design phase is more of the social architecture that is meant to drive the attainment of the envisioned CEMD. The participants were guided into developing a provocative statement, which is a statement of possibility. This statement is meant to bind them toward one common goal, upon which everyone will focus energy to attain. This was done through discussion and consensus and ultimately a challenging affirmative statement, which everybody agreed upon, was phrased as

"Lesotho amazes the world: Primitive maternal deaths down to zero by 2015"

The development of a provocative statement was followed by identification of the desired resources to meet the opportunities identified in the dream phase.

3.4.1 Social construction for improving CEMD

The following were identified by participants as resources that are necessary to realize the ideal system of CEMD in Lesotho: Information sharing, Improved infrastructure, Availability of Human Resources and Availability of commodities.

3.4.1.1 Information sharing

The participants agreed that there is a need to put in place the mechanisms that will enable communication and information sharing in all directions. This was termed a multifocal communication. This could be achieved through community gatherings, mass media disseminations and interpersonal communication at grassroots level.

3.4.1.2 Improved infrastructure

Most health facilities in Lesotho are situated in inaccessible areas. The roads are not good and this threatens accessibility of health services to pregnant mothers. They identified a need to engage information technology in these areas to enable health care providers working in these areas to gain knowledge and get guidance through e-learning. Examples cited were an interaction between a midwife in a remote area and the obstetrician at the referral hospital regarding care of the mother through tele-medicine or e-phones. The government should also commit to construction of roads through a multi-sectoral approach.

While insufficient infrastructure at facility level was a problem in the past, recently the government of Lesotho engaged in an exercise of renovating and equipping all health centres in Lesotho, both government and CHAL owned, through the Millennium Cooperation Account (MCA).

3.4.1.3 Availability of Human Resources

Lesotho like other countries in the African such as Ethiopia is facing, not only shortages in human resources for health but also imbalances. These problems are brought about by these countries' limited capacity in producing human resources as well as retaining them, particularly in remote areas (Teklehaimanot, D. and Teklehaimanot, A., 2013: 2). These shortages can occur at departmental or national level. While the government is investing a lot in training of human resources for health, there is often an attrition of such resources to affluent countries. The participants are of the opinion that there should be stringent retention strategies in place to secure doctors and midwives for the benefit of maternal and child health care services. They also pointed out a need to create pillars in maternity care, these are said to be highly skilled doctors and midwives whose interest and period of stay in MCH has given them a vast experience in maternal and child health.

3.4.1.4 Availability of commodities

During maternal assessment, another area that is being assessed is the administrative contribution in a maternal death. Shortage of material resources is often cited in this area. Participants felt that for the CEMD in Lesotho to be successful, there is a need to provide adequate material resources and appropriate facilities.

3.5 CONCLUSION

The commitment and vigilance which the participants showed in analysing data that was to map out their improved system indicated their commitment to the whole system. The analysis did not only end at achieving the purpose of the study which was to describe the strengths of the system but further depicted the means of improving it. AI being an action research is all about outputs and the social structure drawn at the design phase will need close monitoring and evaluation for outcomes.

CHAPTER 4

DISCUSSION OF FINDINGS AND LITERATURE CONTROL

4.1 INTRODUCTION

The previous chapter described the themes that emanated from data collection. This chapter is intended for discussion of the results and control with literature review. The literature review is used to reflect other scholars' opinions and views about the phenomena under discussion. Each theme will be interpreted and supported with literature where necessary. The first theme that emerged from data analysis was government commitment.

4.2 GOVERNMENT COMMITMENT

Commitment is defined by Hornby (2010: 288) as a promise to support someone or something. Government commitment to health services is often signified by the distribution of resources during budget allocation and advocacy policies toward improving health services. A typical example is that of India's commitment to increasing public spending for health from less than 1% of its Gross Domestic Product (GDP) to 3% (Kumar, Chen, Choudhury, Ganju, Mahajan, Sinha and Sen, 2011: 668).

Lesotho extended its commitment to health service delivery, maternal and child health inclusive, by subsidizing most health services at the level of the hospitals and providing free health services at the health centres (Lesotho. Ministry of Health, 2011: 11).

4.2.1 Why government commitment to CEMD?

The CEMD system is a strategy that is intended to be a vehicle for generation of recommendations that shall curb maternal mortality. Governments have to commit to this system because they are the ones who have the right to translate the activities and findings of CEMD into policies and reinforce implementation of the recommendations generated by this system.

The importance of government commitment to CEMD is reiterated by World Health Organization in the text "Beyond the numbers". WHO indicates that many good

programmes usually end when donor funding dries out. This necessitates that governments commit to these programmes and develop their ownership in such a way that they will be sustained beyond donor support (WHO, 2004: 86). Lesotho embraced the notion of ownership by decentralizing responsibility and accountability of health service delivery to local authorities. This is intended to increase accessibility, equity and efficiency (Lesotho. Ministry of Health, 2011: 6). CEMD in Lesotho is no exception to such programmes.

The process of identifying maternal deaths is seen by Graham (2012: 26) as a basis for a virtuous cycle that informs a call for action, and in this case reduction of maternal mortality. This can be achieved through a sustainable government commitment, which is a buffer of the tension that exist in balancing political power of advocacy and technical realities of monitoring maternal health outcomes. It is therefore important for governments to draw strategic advocacy plans to drive political commitment and resources mobilization in order to realize maternal health and survival of women during procreation as a right rather than a privilege. Graham (2012: 32) identifies national and international fora such as Women Deliver Conference of 2007, G8 meetings and International Parliamentary Union, as platforms for advocacy where government commitment can be elicited at the highest political level. These efforts often result in innovative financing strategies such as Performance Based Funding. Lesotho can also capitalize on such existing platforms or even create opportunities for new platforms where government commitment to CEMD can be elicited. Lesotho is currently piloting the system of performance based funding in health care, even though it is general and not specific to Maternal and Child Health. The participants appreciated the endorsement of CEMD by the MOHSW and see it as the move in the right direction toward ownership of the CEMD, however they indicated that more effort need to be applied to ensure government support in further developing this system.

UNICEF, UNFPA and WHO engaged in an exercise to help Ministries of Health in African Countries to institutionalize Maternal Death Review (MDR). This was successful in Lesotho as the LCCEMD being the secretariat of CEMD is housed within the MOHSW. However the system has not yet attained all the key strategies as outlined by Pearson, de-Bernis and Shoo (2009: 92) in institutionalizing MDR, which are: Creating active advocacy group at the national level, development of

policies, guidelines and tools for MDR, enthusiastic government endorsement of MDR, collaboration with professional bodies, civil society and donor agencies, legal reforms to support MDR Training on CEMD and MDR and incorporation of MDR in the formal government structures.

4.2.1.1 Creating active advocacy group at the national level

Advocacy for maternal and child health services goes beyond individual efforts to a group form. In America, professional organizations, consumer and human rights organizations have formed a group called Coalition for Quality Maternal Care (CQM C). This group became a mouth piece to advocate for a change in national strategies to improve the quality and value of maternal and newborn health care (Association of women's health, obstetric and neonatal nurses, 2011: 343). These strategies include ensuring access to affordable high quality maternity care, promoting care that is evidence based, improving maternal care choices for women and reducing disparities in maternal and newborn outcomes (Association of women's health, obstetric and neonatal nurses, 2011: 344).

While the LCCEMD is playing a key role in making CEMD known, there is still a need for a multi-disciplinary advocacy team to be built in order to drive the issues of MDR in Lesotho. The resounding approval of commitment was echoed by participants as they see a launch of CARMMA as a good political strategy to advocate for CEMD issues at the parliamentary level.

4.2.1.2 Development of policies, guidelines and tools for MDR

National policies and guidelines are cited by Pearson et al (2009: 93) as a crucial factor in in MDR. They however disputed the fact that they can guarantee implementation of MDR on a large scale. They recommended that these tools should be disseminated to the programme managers at the provincial and district level; and support be solicited from them in order to realize their implementation.

Lesotho is doing well on this aspect as it has in place all tools that aid the review from death notification through to collating data (Lesotho. Ministry of Health, 2009). Participants also believe that, while policies are available, there is a great need to share them across all levels so that they can be known by all.

4.2.1.3 Enthusiastic government endorsement of MDR

Pearson et al (2009 93) indicated that government ownership and commitment to MDR is critical in curbing maternal deaths. This enables them to allocate enough resources to sustain this system and oversee its success.

Endorsement of MDR by the government of Lesotho has been identified as the priority strength of the CEMD system in Lesotho. All the groups acknowledged the fact that the government has adopted CEMD as the hope that maternal death reviews shall be done accordingly. One presenter reiterated others in her presentation "*We echo the presentation that has been done about the commitment that the government of Lesotho has toward the reduction of maternal mortality and whose first step was maternal mortality reviews*" Endorsement however does not necessarily spell out commitment; therefore there is still a need to advocate for more government commitment in CEMD. Lesotho reviewed its national reproductive policy in 2009, to include amongst the guiding principles, government leadership and commitment. The government was committed to create an enabling environment and coordinate programmes on sexual and reproductive health (Lesotho, Ministry of Health and Social Welfare, 2009: 10).

4.2.1.4 Collaboration with professional bodies, civil society and donor agencies

External technical and financial support is necessary in developing national MDR policy and strategy. It is also important to incorporate within the support, capacity building in the form of trainings, experience exchange and technical assistance, thus MDR need to be a collaborated effort between governments and external agencies (Pearson et al 2009:93). The national reproductive policy for Lesotho advocate for partnerships and collaboration with all stakeholders to improve mobilization of resources and avoid duplication of efforts (Lesotho, Ministry of Health and Social Welfare, 2009: 10).

CEMD in Lesotho is mainly donor oriented. Professional bodies and civil society are minimally involved. However within the health fraternity, multidisciplinary teams were formed in assessing maternal deaths "*In the group assessments, there were people of different disciplines who were involved, even in one discipline people of different*

cadres, so the shared experiences enabled us to identify the problems and provide resolutions for them" indicated one of the participants in presenting on behalf of her group. It is however important to involve professional bodies and the civil society in CEMD in order to strengthen this system. This can be achieved by including MDR in the curricula of health professionals as well as in professional regulatory guidelines.

4.2.1.5 Legal reforms to support MDR

Maternal health is regarded as a fundamental human right and cited as having a close relationship with the right to highest attainable standard of health. This right has been endorsed by regional and international treaties (Mesquita and Kismodi, 2012: 79). WHO (2004: 40) in the article "*Beyond the numbers*" indicated that maternal death reviews require legal protection particularly around access to information, protection of people involved and the used of the findings Lesotho, being the member state of the UN acknowledges reproductive health as a human right and has made maternal death notifiable. It is however unfortunate that there are no legal measures that are supporting interventions against those who do not report maternal deaths. The LCCEMD has recently launched the first report on Confidential Enquiries but the committee members have concerns that this report might be used by the community as a basis for lawsuits, particularly so where maternal deaths were said to be avoidable. The participants indicated that this happens because the community does not know about CEMD and where it is known, they still do not understand the purpose of this system.

4.2.1.6 Training on CEMD and MDR

Skills transfer on issues of MDR, from the national to the local level is regarded as important by Pearson et al, (2009: 90). This could be done for advocacy purposes to introduce the concept of MDR and its processes or to impart the necessary skills for maternal and child safety. It is important for countries to share experiences on what works in MDR, therefore study tours to countries which have implemented MDR successfully would be of benefit (Pearson et al, 2009: 90). Lesotho took such a study tour to South Africa, which has been implementing CEMD since 1997.

The LCCEMD, in training targeted orientation on CEMD and MDR in in-service training at the national, district and facility levels. Participants see training as a

crucial element of CEMD that drives the whole process. The participants indicated that the LCCEMD is conducting trainings on EMONC and the process of MDR, this however is happening as in-service training only. Participants believe that conducting pre-service training on the system of CEMD will strengthen this system as prospective health professionals will exit the educational institutions with knowledge of what CEMD is all about and skilled in conducting maternal death review.

4.2.1.7 Incorporation MDR in the formal government structures.

According to Pearson et al (2009: 93) MDR becomes sustainable if it is integrated into the maternal and reproductive health programmes rather than running vertically. This aids allocation of resources and other technical areas such as infrastructure, logistics and supplies.

According to the participants, Lesotho has attained this very well as the CEMD system is part of the MOH and the LCCEMD secretariat is housed within the Reproductive Health Division of this ministry. The obstacle however in this key strategy is that this system does not have a focal person or a budget line within MOH. It receives funding from a development partner, UNFPA, and this threatens the sustainability of the system beyond donor funding (Lesotho, Ministry of Health, 2011: 29).

UNFPA as a partner of the Government of Lesotho is currently supporting the activities of CEMD in Lesotho. The MOH however, needs to put in place strategies that will ensure sustainability of the mapped out ideal system of CEMD in Lesotho. The United Nations, through its Human Rights Committee on Elimination of Discrimination Against Women (CEDAW) established that, even if governments can outsource maternal and child health services to private health institutions, they remain directly responsible and accountable for the actions of such institutions and the outcome of care, hence the need to fully commit (Mesquita and Kismodi, 2012: 79). This requires collaboration of all stakeholders within the CEMD and MOH. This collaborated effort is supported by the theory of collectivism which asserts that, contrary to individualism, collectivism emphasizes interdependence, shared interest and equality (Cho and Yoon, 2009: 64). Strongly integrated and cohesive groups tend to be more effective as they share ideas and decision making.

Hussein and Okonofua (2012: 13) see the concepts of collaboration and collectivism as encompassed within the concept of accountability. They identified two traditional huddles that prevent stakeholders of CEMD from committing to accountability for reduction of maternal deaths; which are lack of control and appalling blame. Contrary to the views of these authors, the participants still regard CEMD in Lesotho as non-judgemental and not fault finding.

It is imperative therefore to conclude that the participants are right to identify Government commitment to CEMD as a key factor in attaining the ideal CEMD system in Lesotho.

4.3 COMMUNICATION AND FEEDBACK IN ALL DIRECTIONS

Communication is defined by Meyer, Naudé, Shangase and Van Niekerk (2009: 265) as an interactive, dynamic and continuous process between people. It entails both transfer and interpretation of the message. Feedback is intertwined in communication. It refers to acknowledgement of receipt and understanding of the message.

The main purpose of conducting maternal death reviews is to identify the pitfalls that led to the mother's death as well as generating recommendations that will improve maternal and child health care; thus preventing further deaths. The information gathered from the reviews would not be of any help if it is not disseminated to all stakeholders. It is important that feedback regarding maternal death reviews is disseminated at various levels of health care and to all stakeholders. The study was aimed at identifying and describing the strengths of the CEMD in Lesotho, thus using them as a platform of aspiration for an improved system.

There is a remarkable interrelationship between theme 2; feedback and theme 3; communication as one is the vehicle for another. The feedback that stakeholders of CEMD cited as important in improving their system is transmitted through communication. This can be done through a number of media; radios, television, public gatherings etc. Mcnair (2011: 13) cited media as an important tool in the political process where publicity and lobbying for votes are important. This notion can be helpful also where public opinion is required regarding health services and in particular issues of maternal death review. Since communication is a two way

process, policy makers also at the ministerial level can use the medium of communication to transmit guidelines regarding CEMD, the processes as well as the results (Meyer et at, 2009: 266). This has been clearly portrayed by the participants in a collage depicted in figure 9, where the Minister of Health in South Africa was shown during an interview.

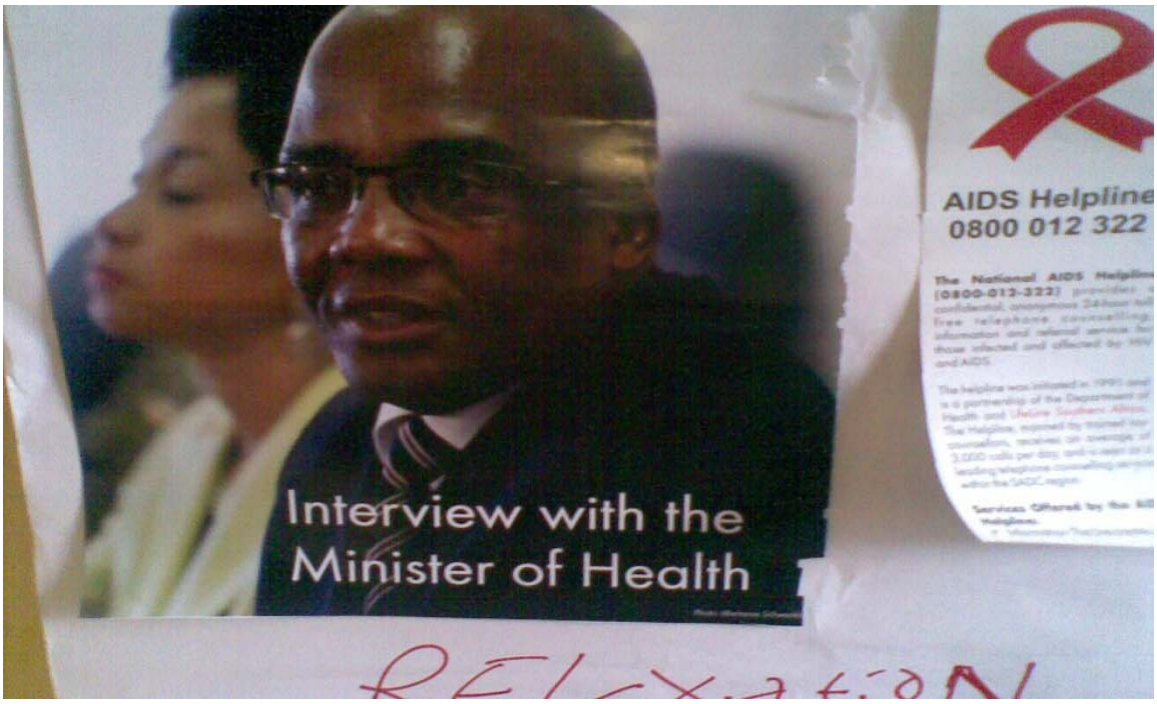

Figure 9: Communication from policy making level

The LCCEMD is seen as the central point for communication. The facilities report maternal death to this committee at the secretariat. The results of assessment from maternal death assessors are also communicated to the LCCEMD, which will collate the results, compile a report and communicate back the results to all stakeholders for implementation of recommendations.

4.4 APPRECIATING, PRAISING AND RELAXATION

It is the expectation of every mother and her family when she goes to the hospital to give birth that she will come back with a healthy baby. It is equally important for the midwife within the healthcare team to assist the mother to give birth to a healthy baby. Maternal death on its own is depressing, but going over the events that led to the death and realizing that some of the factors that contributed could have been avoided is very daunting. The participants therefore view support and

encouragement to all stakeholders that are involved at any level with the MDR as important.

Maternal death is one of the critical incidents in the labour ward. It often causes stress, drama, and profound disruption in the health workers' functioning, which may be physical or psychological. This requires that the personnel who were caring for the diseased woman should be debriefed. Applied effectively, debriefing is cited to reduce both short term and long term reactions or psychological trauma (Hill, 2012: 85). Hill (2012: 85) further highlighted the importance of support of the caring team by the nursing management, physicians, hospital clergy, social workers, employee assistance and bereavement counsellors and the hospital administration. CEMD in Lesotho was incepted in 2009, there was no anticipation then of the emotional and psychological sequelae that was to follow maternal death reviews.

The participants reported that one aspect of the CEMD that they see as the strength is the support that they received from the LCCEMD when they experienced stress and to others even depression symptoms. Initially the assessors were doing this job individually. The LCCEMD resorted to assessing maternal deaths in a group when participants reported signs of stress and other serious psychological symptoms that saw some assessors receiving professional counselling. Other measures that were taken were periodic retreats where they had fellowship sessions, even though the hospital clergies were not part of them**.**

The idea of support and encouragement of health personnel involved in either care or review of maternal death emanates from an increasing recognition of mental health and psychological wellbeing. McCready and Russell (2009: 1213) indicate that lack of support to personnel dealing with MDR is likely to result in short term sequalae such as self-criticism, blame culture, loss of confidence and vulnerability to more errors, while at the same time long term impacts such as depression, nervous breakdown, suicidal ideations and prolonged periods of sick leaves have been reported. While other impacts delineated by McCready and Russell have not be reported by the participants, stress and depression were reported to have been common at the earlier stages of CEMD in Lesotho.

Lesotho, unlike developed countries such as the United Kingdom does not have trusts established to provide support systems for carers following a maternal death

and or review. Countries that have this system also still encounter challenges as the transfer of information on it is not optimum; therefore is not fully utilized (McCready and Russell, 2009: 1213).

According to the participants, the problem of psychological impact of MDR in Lesotho was overcome by group assessment of MDR reports. All assessors were convened in a workshop and assess maternal deaths together. The participants however felt that this is not enough. They suggested that if CEMD in Lesotho is to develop to its highest potential, the stakeholders need to be supported in the form of appreciation, praise and relaxation techniques. A survey conducted amongst the anaesthetic teams who experienced trauma of a maternal death in the United Kingdom, revealed that, 34 per cent of participants had received support following a maternal death. The support however was informally from their colleagues. They indicated that they would have benefited more from the support in the form of debriefing and counselling (McCready and Russell, 2009: 1212). The report of this survey recommended that trusts must provide for prompt support and counselling for all health personnel who have cared for a woman who died (McCready and Russell, 2009: 1211). Lesotho could benefit from the system of trusts and incorporate debriefing and counselling in them.

4.5 TRAINING AND MONITORING

Training and monitoring plays a vital role in MDR and CEMD. There are a number of activities that are undertaken in MDR that require people who are keen and knowledgeable about what they are doing. WHO (2004: 95) emphasises the importance of training to the following groups: data collectors, interviewers and assessors on issues of MDR. Data collectors are seen as very important, particularly in facility based reviews and confidential enquiries as they need to ensure that the processes are followed appropriately and the maternal death notification form is appropriately completed. The trainees should undergo both theory and practical training on the purpose of investigations, the importance of confidentiality and non-biasness, and the use of tools (WHO, 2004: 31). They appreciated the fact that LCCEMD has trained all the facilities' MCH personnel on the processes involved in CEMD. The assessors were also trained on conducting maternal death assessments. The participants however see training in CEMD as a continuous

process because it is meant to address changes in human resources circulation. They also see training as an engine that drives the processes of CEMD and the brain that sustains it.

Immediately after the inception of CEMD, the LCCEMD trained doctors and midwives both on EMONC and the processes of CEMD, but the implementation phase had challenges. The doctors and midwives that were trained were not able to engage in MDR activities for various reasons, while others left the country (Lesotho, Ministry of Health, 2013: 3).

Monitoring is a systematic collection and analysis of information as the project or organization progresses. It is aimed at improving the effectiveness and efficiency of the project and compares the actual activities with the performance plan (Lesotho. Department of rural water supply, 2012: 3). It culminates in the evaluation of the whole system. The process of CEMD in itself is a monitoring measure for maternal mortality. It assesses the scale of maternal mortality, its causes and measures taken to address it. Hunt and Mesquita (nd: 12) see monitoring as a key feature in attaining the right to health for women in procreation. It helps in assessing progress of identified indicators and enables adjustment of policies to attain their set targets. Since the inception of CEMD, the LCCEMD, has been doing a continuous monitoring of all processes relating to MDR and this culminated in the release of the first CEMD report in 2013, named "*Polokeho Tharing*", which means safety in procreation.

The Maternal Mortality Ratio for Lesotho is currently at 1155/ 100 000 live births, an indication of poor progress toward attainment of MDG 5 by 2015. Two of the important recommendations relevant to training and monitoring, that were made in *Polokeho Tharing*; improving monitoring at all stages of pregnancy, labour, delivery and postpartum period and critical development of guidelines and capacity building in emergency obstetric care thus complementing the views of the participants in this regard.

4.6 ACTION PLAN

The current situation is that Lesotho is off track in as far as attaining MDG 5; however the participants, on behalf of all stakeholders of CEMD in Lesotho have taken a bold stand to reverse the situation. This is evident in their design phase

where their provocative statement "*Lesotho amazes the world: Primitive maternal deaths down to zero by 2015"* which indicates their commitment. Primitive causes of maternal deaths are those that are avoidable. A focus has been shifted from a general reduction of maternal deaths by 75% by 2015 to address first the primitive causes. They realized that for them to eat the whole of this elephant 'Maternal Mortality" they need to cut it and chew it into pieces; the first piece, avoidable causes. Avoidable causes are responsible for a large chunk of maternal deaths in Lesotho, constituting 91.6% (Lesotho. Ministry of Health, 2013: 22). A reduction and or elimination of these avoidable causes of maternal deaths will enable Lesotho to go back to track and attain MDG 5 by 2015. The participants agreed that they have the capacity to avert maternal deaths from avoidable factors. The participants designed a social structure that will enable them to achieve this. The point of departure for this structure is a multidisciplinary approach. It is also vitally important to map out how all the disciplines that are directly or indirectly involved in CEMD will converge over the goal of eradicating avoidable factors. Such disciplines include: medicine and allied health sciences, administration, communities etc. These would be addressed in four areas collectively referred to as an enabling environment:

- Information sharing
- Improved infrastructure in health facilities
- Availability of human resources
- Availability of commodities

Even though the participants did not approach their social structure of attaining MDG 5 from the angle of human rights based approach, Hunt and Mesquita (nd: 13) view this approach as instrumental in the reduction of maternal mortality. It reinforces commitment of governments, international organizations, donors and civil society in policy making, clinical practice, support and empowerment.

This is supported by the Partnership for Maternal, Newborn and Child Health (PMNCH) (2011: 8) whereby special emphasis is put on strengthening the health care system across policy-to-practice by availing the following rights:

4.6.1 The right people

This ranges from the right leadership and governance, human resources and right individuals and communities (PMNCH 2011: 22). Although Lesotho is already gearing its focus on improving human resource for MCH service, it is however important to include strong leadership and governance structures within CEMD to strengthen it. The researcher purposely included the policy makers in this study so that they can advocate for the rights of mothers at procreation by availing all the necessary resources. Maternal and community participation in matters relating to CEMD is of prime importance as some of the causes are patient oriented and some happen merely because the community is not aware of its contribution to it (WHO 2004: 30). Feedback in the form of recommendations should be given to the community and women groups to help them in their advocacy strategies and understanding key measures regarding their pregnancy (WHO, 2004: 83). The participants have put forward availability of human resources and commodities as part of the social structure that is aimed at improving the CEMD system; thus improve maternal and child health and ultimately reduce maternal mortality.

4.6.2 The right place

The report, "*Polokeho Tharing*" outlines the trends of maternal mortality in Lesotho. One such trend is demographic distribution (Lesotho. Ministry of Health, 2013: 8). According to Lesotho has to commit more resources where there is the highest need and burden. Distribution per district indicates that Maseru has the highest proportion of maternal deaths (46.7%) (Lesotho. Ministry of Health, 2013: 8). This is rightfully so because the only level 3 (referral) hospital; the then Queen Elizabeth II and now Queen 'Mamohato Memorial Hospital is found in this district. It is however important for the LCCEMD to acknowledge again the topography of the country whereby accessibility to health care services is hampered by poor or lack of roads, mostly in the rural areas (Lesotho. Ministry of Health, 2011: 10). These facilities in the mountains should be regarded as high need even though they may not bear the same burden as the level 3 hospital in Maseru.

The right place again relates to infrastructure and facilities, which are already a concern for the participants in AI. The health facilities in the country are currently undergoing renovation under Millennium Challenge Account (MCA), however the

infrastructural nature of these facilities is not necessarily designed to meet maternal and child health care services only, but general health care. More effort needs to be put in place to advocate for suitability of MCH facilities. The issue of infrastructure for health in Lesotho has been addressed in the national health policy of 2011. The government committed to ensure that the physical infrastructure is standardized and appropriately constructed (Lesotho. Ministry of Health, 2011: 30).

4.6.3 The right resources

This relates to both procurement and management of commodities and supplies such as medicines, vaccines, diagnostics and devices. Lesotho has just piloted a performance based funding on health care in two hospitals to assess its efficiency in financing health services. This move is supported by the Partnership for Maternal, Newborn and Child Health (2011: 9), which indicates that there is a need to maximize financial and technical support for implementation of priority strategies and interventions and advocate for evidence based and efficient spending.

4.6.4 Doing the right activities

These include quality health care, health promotion and health literacy. Emphasis is put by stakeholders on the efficiency of information systems will enable them to access data about maternal and child health care indicators, communication through the media which are seen as a web that disseminates information from the policy making to the grassroots and vice versa. A typical example is given in the collage where they depicted the importance of feedback and communication between the LCCEMD and all other stakeholders in the CEMD system. Inter-sectorial linkages are well advocated for in the wishes of the participants, where they indicated that it would be important for other health professionals like the pharmacists to be part of the CEMD as some of the causes of maternal deaths emanate directly or indirectly from other sectors such as nutrition This inter-sectoral approach is advocated for by WHO (2004: 29) which warns against parallel health care systems by various ministries such as that of Health, ministry of social welfare or even of agriculture.

4.6 5 Achieving the right results

The ultimate goal of CEMD is to generate recommendations that will improve maternal and child care, thus reducing maternal mortality. Key to positive outcomes are universal access and equity to health services and accountability at all levels (The Partnership for Maternal, Neonatal and Child Health, 2011: 22).

4.7 CONCLUSION

The stakeholders of CEMD in Lesotho are aware of their strongholds in this system. They also have aspirations for an ideal system of CEMD. Central to all of these are the key strategies that they would like to use to realize their envisaged ideal system of CEMD. These strategies include improving the communication system in order to share information, improving infrastructure in the health facilities, strengthening human resources capacity and availing more commodities.

CHAPTER 5

RECOMMENDATIONS

5.1 INTRODUCTION

The purpose of this chapter is to reflect on important points of the study, both on the processes and results. The researcher undertakes retrospection and assesses whether research questions have been answered and the aim of the study was achieved. It also delineates the limitations of the study and the recommendations in various areas that have a bearing on CEMD and are likely to play a vital role in improving this system in Lesotho.

The system of CEMD in Lesotho is very young, having released the first report in 2013. It has however seen significant progress in an effort to account for and reduce maternal deaths. The aim of this study was to describe through AI the strengths of this system in an effort to use them as building blocks for stakeholders to aspire for more and improve the system. The aim of the study and the first research question were achieved as the participants were able to identify the strengths of CEMD system. They also reflected in a collage, the kind of CEMD system they aspire to have in future. Lastly they constructed the plan of action that will enable them to attain their envisaged ideal system of CEMD.

The researcher's strategy of using AI for this study was worthwhile. Participants appreciated the fact that they are not being criticized for failures of the system. They are instead being encouraged to develop it further. This was reflected very well in the discovery phase where they were comparing the CEMD system with AI for their non-judgmental nature whereby the purpose of engaging in them is not fault finding but reaching a common positive goal.

Explanation of the AI process by the facilitator at the beginning of the data collection put participants at ease and the whole session of data collection was fun. They were at first surprised that they are expected to see the positive core in an exercise that in itself is depressing; maternal death reviews. It was difficult for them to relate memorable stories about a death, but they later saw a bigger picture of success stories in this exercise. The second question was answered as the participants

expressed an appreciation of the strength to strength nature of AI and how asking a positive core enabled them to aspire for a better CEMD system.

While there were diverse ideas in the questions in discovery, the closing wishes focussed on common goals such as abolishing the system of CEMD by 2015 as there would be no need for it when they will have worked hard enough to eradicate maternal deaths. Maternal deaths will be limited only to unavoidable causes, the community will be in a position to understand the purpose of CEMD and be actively involved in it and many others delineated in data analysis.

The highlight of the study was the dream phase whereby participants mapped out in a collage the ideal CEMD system for Lesotho. This dream emanated from the consensus strengths elicited through nominal group technique earlier. The ideal system was delineated to be one in which there is full government/political commitment, where there is feedback in all directions, communication, participants are appreciated for their hard work with praising and relaxation. Training and monitoring are seen as an integral part of this ideal system, which must endorse full confidentiality. This envisaged ideal system has prompted the participants to draw a statement of intend; provocative statement that read thus; **Lesotho amazes the world: Primitive maternal deaths down to zero by 2015".**This statement reflects the reality that the system is geared at reducing maternal deaths, not completely eradicating them because there are those that are unavoidable**.** However it comes also as a strategy that participants intend to use to reduce maternal deaths by eliminating those that are within their control because they are avoidable; thus achieving a reduction of 75% by 2015.

While study processes were successful and objectives were achieved, this was not without challenges; thus the next section addresses the limitations to the study.

5.2 LIMITATIONS OF THE STUDY

Appreciative Inquiry was a new concept to the stakeholders of CEMD, particularly those who had to authorize the study to continue; therefore it took them time to get convinced of the value of the study. This brought about a delay in data collection as well as unavailability of policy makers when ultimately the AI workshop was held.

Accessing participants was a hustle as they are not all necessarily employees of the MOH, some are employed in private and faith-based institutions, and therefore there was a need for extensive negotiation of their release to participate in the study. The researcher had to wait for the scheduled workshop for maternal death assessors and use it as an opportunity for AI workshop; thus causing a delay in collecting data.

The anchor of the study was busy as she is also running Maternal and Child Health Programmes of the MOH, thus she was not able to facilitate a timely entry of the researcher into the study setting.

While the sample size was adequate, the sampling criterion was not fully met. Some participants, by nature of their work within the MOH were playing a dual role in the study, that of LCCEMD members and of policy makers.

5.3 RECOMMENDATIONS

The discussion of findings resulted in a number of issues that require an improvement in a various settings; namely education, management, clinical practice, research, the LCCEMD secretariat and professional regulatory bodies.

5.3.1 Education

Training institutions are a fountain for midwifery and obstetric services therefore need to keep abreast with new developments in care, and in this case specifically maternal and child health care. It would be very important for the Midwifery Education system in Lesotho to incorporate issues of Maternal Death Review in all Midwifery Curricula so as to enable newly qualified midwives to come into practice already conversant with the MDR systems used in the country.

Midwifery students and other health professionals should be given an opportunity to be part of and make meaningful contribution to the facility based reviews following a

maternal death. This way they are being mentored to hold own reviews once qualified.

There is also a need for in-service training for all health professionals who take care of mothers at procreation. The training and education departments of health facilities are therefore encouraged to include MDR in their annual in-service training plans.

5.3.2 Management of maternal and child healthcare facilities

Nurse Managers, Nursing officers and Administrators should support MDR and encourage for Facility based reviews to be held following a maternal death. They should heed the guidance given by the LCCEMD in terms of time and the processes that are to be followed in conducting such.

Nurse Managers together with the office of Training should plan inductive trainings on issues of MDR and also release personnel for training when requested to do so by the appropriate authorities in MDR.

Managers should also make it their business to gain competency in issues relating to Maternal and Child health including the monitoring processes such as CEMD, this will enable them to provide appropriate supervision and support.

Managers and Administrators should also advocate for more and skilled personnel in MCH units.

5.3.3 Clinical Practice

The elements that construct a strong CEMD system must be shared with all clinicians and health personnel that are working with MCH services.

All Health facilities must report a death of a mother immediately to the LCCEMD and receive a special number for that case.

Maternal death reviews must be held within the twenty-four hours of reporting and a maternal death notification form should be filled and forwarded to the LCCEMD.

All health professionals who are caring for women at procreation should be part of the MDR team as such reviews are a learning experience and meant to avoid similar problems from repeating in future.

5.3.4 Research

Given the topography of Lesotho and the challenges identified in the CEMD report "*Polokeho Tharing*", the researcher recommends that there be more research geared toward the most appropriate method of MDR for Lesotho, even if it could mean a combination of more than one method. This is so because the report indicated that there are still many home confinements; thus some deaths may not have been reported because they did not occur in the facility.

There is also a need for a more comprehensive study of the same nature, but one that will cover the entire country, particularly the facility based maternal death review teams, who, in this study were represented by one facility, which is QMMH. This comprehensive study should have separate policy makers who are not playing dual roles in CEMD.

5.3.5 Professional regulatory bodies

The results of the study will be shared with the two professional regulatory bodies in Lesotho; Lesotho Nursing Council (LNC) and Lesotho Medical, Dental and Pharmacy Council (LMDPC)

The researcher, who is also the Chairperson of LNC, believes these professional regulatory bodies need to play an active role in guiding and regulating MDR in the country. This can be achieved by including MDR in scopes of practice, standards of care and Continuing Professional Development (CPD) programme for their registrants.

5.3.6 The LCCEMD Secretariat

The LCCEMD is playing the key role in CEMD in Lesotho. It is seen as a source of policies for all activities relating to CEMD, but also the recipient of all outcomes of this system. It is therefore imperative to conclude that the strengths of this Committee are the strengths of the whole system; the same applies for its weaknesses.

The LCCEMD has to engage into a vigorous advocacy for political commitment and feasible sustainability plans beyond the donor support.

The following recommendations were made:

- Develop a more formalized system of support, particularly emotional and psychological for all those participating in CEMD activities.
- Solidify the governance structures of CEMD with more MOH officials to understudy partner‘s officials.
- Advocate for more resources; human and material.
- Introduce verbal autopsies in hard to reach areas where mothers are not able to access health care from the facilities but still die at home.
- Engage the communities in CEMD so that they can understand the purpose of this system and not use it as a legal ground for lawsuits.

5.4 CONCLUSION

The system of CEMD in Lesotho is well established and has a number of strengths. There is however more room for improvement, particularly because Lesotho is off track in as far as attaining MDG 5, thus they need a strong system that can be able to identify deaths, map out the causes and recommend strategies to reduce them. The stakeholders of this system are already on the right track of improving it. They have action plans in place, but those cannot yield positive outcomes if they are not implemented. The idea of reducing maternal deaths one step at the time “*cutting the elephant in pieces*” is a good one, starting with avoidable causes of maternal deaths. Their positive regard for their system is reflected in the provocative statement “*Lesotho amazes the world: Primitive causes of maternal death down to zero by 2015”*, a clear intend of where they want to see this system in 2015. A continuous appreciation of the positive core in this system is surely going to strengthen this system and enable it to make recommendations that will curb maternal deaths in Lesotho.

6. REFERENCES

Aldred, R. 2011. “From community participation to organizational therapy?: World café and Appreciative Inquiry as research methods”. Community Development Journal. (Online) 46 (1), 57-71. Available from: cdj.oxfordjournals.org [Accessed: 30, April 2011].

Association of Women’s health, Obstetric and Neonatal Nurses. 2011. Coalition for quality maternal care: advocating for mothers and newborns. Nursing for women’s health. 15 (4), 343-345, September.

Barret, F.J. & Ronald, E.F. 2008, Appreciative Inquiry: A positive approach to building cooperative capacity. New York: Taos Institute.

Borys, T. 2012. “Sustainable Development as an axiological and civilizationChallenge”.*In* Loukola, O. & Gasparski, W.W. (eds.) Environmental political philosophy. New Jersey: Transaction Publishers.

Botma, Y., Greef, M., Mulaudzi, F.M. & Wright, S.C.D. 2010. Research in Health Science. Cape Town: Pearson Education.

Brink, H., Van der Walt, C. & Van Rensburg, G. 2012. Fundamentals of Research Methodology for Health Care Professionals. 3rd ed. Cape Town: Juta.

Burns, N. & Grove, K.S. 2009. The Practice of Nursing Research; Appraisal, Synthesis and Generation of Evidence. 6th ed. St Louis: Elsevier.

Chapman, L. & Giles, D. 2009. “Using Appreciative Inquiry to explore the professional practice of a Midwifery Lecturer” Studies in Continuing Education. 31 (3), 297-305, November.

Cho, T. & Yoon, S. 2009. “Human Resources Management, Individualism-Collectivism, and Individual Performance among Public Employees: A test of the Main and Moderating Effects”. Korean Journal of policy Studies. 23 (2), 57-78, February.

Conn, L.G., Oandasan, I.F., Creede, C., Jakubovicz, D. & Wilson, L. 2010. Creating Sustainable Change in the Inter professional Academic Primary Care Setting: Appreciative Inquiry Approach. Journal of Research in Inter professional Practice and Education.1 (3), 284-300, December.

Cooperrider, D.L, Whitney, D. & Stavros, J.M. 2008. Appreciative Inquiry Handbook for Leaders of change. 2nd ed. Brunswick: Crown custom publishing.

Cooperrider, D.L. & Whitney, D. 2011, .Appreciative Inquiry: A positive revolution in change. (Online). Available from: http://www.positivechange.org/about-us/appreciative- inquiry.html [Assessed: 13, March 2011].

Cooperrider, D.L. 2012. The concentration effects of strengths: How the whole “AI” summit brings out the best in human enterprise. Organizational Dynamics.41 (2), 106-117, April.

Coulson, N., Goldstone, C., Ntuli, A. & Pillay, N. 2010. Developing Capacity for Health: A Practical Approach. Sandton: Heinemann.

De Kock, J. & Van der Walt, C. 2004. Maternal and Newborn Care: A complete guide for midwives and other health professionals. Lansdowne: Juta and Co.

De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. 2011. Research at Grass roots: For the social sciences and human service professions. 4th ed. Pretoria: Van Schaik Publishers.

Drife, J. 2012. The value of Confidential Enquiries. South African Journal of Obstetrics and Gynaecology. 18 (2), 32-36.

Elo, S. & Kyngäs, H. 2007. The qualitative content analysis process. Journal of Advanced Nursing. 62 (1), 107-115, November.

Graham, J. 2012. "The Politics of Progress: The Story of Maternal Mortality" *In* Hussein, J., Mc-Caw-Bins, A. & Webber, R. Maternal and Perinatal Health in Developing Countries. CABI: Cambridge.

Hill, P.E. 2012. Support and counselling after maternal death. Seminar Perinatal. 36, 84-88.

Hornby, S. 2010. Oxford advanced learner's dictionary. New York: Oxford University press.

Hunt, P. & Mesquita, B.J. Nd. Reducing Maternal mortality; the Contribution of the Right to the Highest Attainable Standard of Health. United Nations Population Fund. 1-16.

Hussein, J. & Okonofua, F. 2012. Time for Action: Audit, Accountability and Confidential Enquiries into Maternal Deaths in Nigeria. African Journal of Reproductive Health. 16 (1), 1-15, March.

Kumar, A.S.K., Chen, L.C., Choudhury, M., Kanju, S., Mahajan, V., Sinha, A. and Sen, A. 2011. Financing health care for all: challenges and opportunities. Lancet. 337, 668-679, February.

Kundi, G.M. & Nawaz, A. 2010. From objectivism to social constructivism: The impacts of Information and Communication Technologies (ICTs) on higher education. Journal of Science and Technology Education Research.1 (2), 30-36, July.

Lapan, S.D. & Quartaroli, M.T. 2009. Research Essentials: An Introduction to Designs and Practices. San Francisco: Jossey-Bass.

Lesotho. Ministry of Health and Social Welfare. 2009a. Lesotho Demographic and Health Survey. Maryland: ICF Marco.

Lesotho. Ministry of Health and Social Welfare. 2009b. Lesotho Maternal Death Review Tools. Maseru: Government Printers.

Lesotho. Ministry of health and Social Welfare. 2009c. National Reproductive Health Policy. Maseru: Government Printers.

Lesotho. Ministry of Health and Social Welfare. 2010. Annual Joint Review Report. Maseru: Government Printers.

Lesotho. Ministry of Health. 2011. National Health Policy. Maseru: Government Printers.

Lesotho. Department of Rural Water Supply. 2012. Revised activity monitoring plan. Millennium Challenge Account. 1-40, March

Lesotho. Ministry of Health. 2013. Polokeho Thering. Maseru: Government Printers.

LoBiondo-Wood, G. & Haber, J. 2006. Nursing Research: Methods and Critical Appraisal for Evidence –Based Practice. New York: Mosby.

Mesquita, J.B. & Kismodi, E. 2012. Maternal Mortality and Human Rights: Landmark decision by United Nations Human Rights Body. Bulletin World Health Organization. 90 (2), 79-79A, February

Meyer,S. M., Naudé, M., Shangase, N.C. & Van Niekerk. 2009. The Nursing unit manager: A comprehensive guide. 3rd ed. Cape Town: Heinemann.

Mcnair, B. 2011. Introduction to political communication. 5th ed. Milton Park: Routledge.

McCready, S. & Russell, R. 2009. A national survey of support and counselling after maternal death. Journal of the Association of Anaesthetists of Great Britain and Ireland. 64, 1211-1217, July

Oladapo, O.T., Adetoro, O.O., Fakeye, O., Ekele, B.A., Fawole, A.O., Abasiattai, A., Kuti, O., Tukur, J., Ande, A.B.A. & Dada, O.A. 2009. National data system on near miss and maternal death: shifting from maternal risk to public health impact in Nigeria. Reproductive Health. 6 (8), June.

Pearson, L., de-Bernis, L & Shoo, R. 2009.Averting maternal death and disability: International Journal of Gynaecology and Obstetrics. 106, 89-93.

Petit, C.S. Huault, J. & 2008. From Practice-based Knowledge to Practice of Research: Revisiting constructivism Research Works on Knowledge. Management learning (Online). 39(1): Available from: http://mlg.sagepub.com [Accessed: 4, October 2011].

Reed, J. 2007. Appreciative Inquiry: Research for Change. California: Sage publications.

Savasci, F. & Berlin, D.F. 2012.science teacher beliefs and classroom practice related to constructivism in different school settings. J Science Teacher Education. 23, 65-86, January.

South Africa. National Committee on Confidential Enquiries into Maternal Deaths. 2010. Saving Mothers 2008-2010: fifth report into maternal deaths in South Africa. Gauteng: Government Printers.

Teklehaimanot, D.H. and Teklehaimanot, A. 2013. Human resources development for a community health based extension: a case study from Ethiopia. Human resources for health. 11 (39), 1-12. August.

The partnership for Maternal, Newborn & Child Health (PMNCH). 2011. Strategic Framework: 2012-2015.

Tlale, N. 2011.Verbal communication with the author on 11 July. Ministry of Health and Social Welfare Lesotho. (Notes in possession of T. Ramaili-Letsie, Roma College of Nursing, Maseru Lesotho.

United Nations. 2010. The Millennium Development Goals Report. New York: United Nations.

United Nations. 2013. The Millennium Development Goals Report. New York: United Nations.

World Health Organization. 2004. Beyond the numbers; reviewing maternal deaths and complications to make pregnancy safer. Geneva: WHO.

Whitney, D. 2010. Appreciative Inquiry: creating spiritual resonance in the work place. Journal of Management, Spirituality and religion. (Online) Available from: http://dx.doi.org/10.1080/14766080903497656 [Accessed 30, April 2011].

ANNEXURE A: ETHICAL APPROVAL FROM THE UNIVERSITY OF FREE STATE

ANNEXURE B: REQUEST FOR PERMISSION TO CONDUCT THE STUDY

Roma College of Nursing

Box 26

Roma 180

21st February 2013

The Chairperson

National Health Research- Ethics Committee

Ministry of Health

Box 504

Maseru 100

Lesotho

RE-REQUEST FOR PERMISSION TO CONDUCT THE STUDY

This correspondence serves as a request for your office to grant me permission to conduct the study in one of the divisions of the Ministry of Health; which is the Confidential Enquiry into Maternal Deaths (CEMD) system. This study entitled "Strengthening the System of Confidential Enquiry into Maternal Deaths (CEMD) in Lesotho" is conducted in partial fulfilment of my academic studies toward a Masters degree in Advanced Midwifery and Neonatology with the University of Free State.

The purpose of the study is to describe through Appreciative Inquiry, the strengths, opportunities and aspirations of all stakeholders involved in the CEMD in Lesotho, with the intention of supporting and strengthening the work of this Committee. I have decided to use an AI research technique with this study because the system of CEMD is new in Lesotho and the stakeholders need to be encouraged to pursue development of this system. An improved CEMD will yield recommendations that will

enable Lesotho to curb down maternal Mortality; thus attain Millennium Development Goal five (MDG5).

The population of the study is all stakeholders involved in the system of CEMD in Lesotho. Data collection will be done in one day, guided by the researcher and an AI specialist. The results of the study will be published and also made available to the Ministry of Health through submission of copies to relevant departments. The results will also be availed to Maternal and Child health departments through presentations that will made in a series of meetings that shall be arranged with convenience. Enclosed are the letter of approval from the University of Free State, study protocol, summary of the proposal and my Curriculum Vitae. I can be reached at this number for any clarifications: +266 63067684. Or e-mail at ltlalane@yahoo.com

Your consideration of this request will be highly appreciated

Yours Sincerely

TlalaneRamaili-Letsie (Researcher)

ANNEXURE C APPROVAL FROM NATIONAL RESEARCH AND ETHICS COMMITTEE (NREC) LESOTHO

ANNEXURE D: INFORMATION LEAFLET

TITLE OF THE STUDY: STRENGTHENING THE SYSTEM OF CONFIDENTIAL ENQUIRY INTO MATERNAL DEATHS (CEMD) IN LESOTHO

INVESTIGATOR: TlalaneRamaili-Letsie

I am a student at the University of Free State, studying toward Masters Degree in Advanced Midwifery and Neonatology. I am conducting a study entitled strengthening the system of Confidential Enquiry in to Maternal Deaths (CEMD) in Lesotho. I request your participation in this study.

The purpose of this study is to describe through Appreciative Inquiry (AI), the strengths, opportunities and aspirations of the stakeholders of CEMD in Lesotho. This research technique will enable the participants to map out the aspired future of the system by reflecting on its strengths and identify strategies that will enable it to attain the aspired future. Contrary to many research techniques that are fault finding, AI is more of a developmental strategy, therefore will put the participants at ease. There are no anticipated harmful impacts from this study.

Participation is limited to stakeholders of CEMD in Lesotho, you are therefore purposeful selected to participate as your experiences in working within this system will be valuable to its progress. Your participation in the study is voluntary. The advantage of participating in this investigation is that; the identified strengths will give the participants the courage to aspire for an ideal future of this system. An ideal system of Confidential Inquiries into Maternal Deaths will generate recommendations that will be used to reduce maternal deaths in Lesotho; thus positively moving toward attainment of MDG 5.

The information will be gathered in a group form. Participants will be convened in a hall for one day and the facilitator will guide them through the process of Appreciative Inquiry. The Researcher will be analyzing data while it is being collected in collaboration with the participants.

The information you give will be treated as confidential as your name will not be mentioned in the investigation but information will be grouped and presented as such. Names will only appear on the permission form, which will be locked away

from the information you give. The information you give will also be locked away in a safe place. It shall not be shared with anyone outside the investigating team, unless you give them a written permission to do so. It is important however, for you to be aware that the results of the investigation will be made known to the public ultimately, for the benefit of health care, and to help improve the system. When this happens, your name will not be used in the information, as similar responses of all participants in the study will be grouped together, therefore cannot be traced to one individual.

Please note that your participation in this study is voluntary. You have a right to refuse to participate if you do not want to. You also have a right to stop taking part at any time if you feel you no longer want to continue and you will not be penalized for such a decision.

The study will not impose any costs to you and there will be no payment made you either, for participating.

Should you have any questions regarding your involvement in this investigation, you can contact Mrs T. Ramaili-Letsie at the following number: +266 63067684

If you agree to participate, you will be given a form to sign as an agreement.

ANNEXURE E: INFORMED CONSENT

I assert here that I have discussed with the participant the study, its benefits, risks and procedure involved. In my opinion she understands his/her rights and is within the appropriate age and frame of mind to consent.

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Investigator's signature Date

I ---------- have read the above information and received appropriate explanation about the study. I am aware that my decision to participate is voluntary and that I can abandon the participation any time without any penalty to pay.

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Participant's signature Date

ANNEXURE F AI PROTOCOL

OUR EXTRAORDINARY SYSTEM OF CONFIDENTIAL ENQUIRIES INTO MATERNAL DEATHS (CEMD):

An appreciation of the strengths of all stakeholders of CEMD in Lesotho

DISCOVERY

CONVERSATIONS IN PAIRS

Thank you for joining us here today to take part in this exciting process. The questions being asked are called **Appreciative Questions**. You are going to ask one another questions about times when you saw things at their best in your work within the CEMD. Often we try to ask about things that are not working well; the problems; so that we can fix them. In this case, however, we will ask questions about things that are working well; **the successes**, so that we can strengthen them.

So the best thing that you can do in this conversation is to think about, remember, and tell your partner in a pair in detail about the positive things you have seen, heard, experienced in your service within the CEMD.

SUGGESTED TIME LIMIT: 2 HOURS

1. Tell me about a peak experience, or high point, in your work within the CEMD? A time that you felt alive, most engaged, or really proud of what you did.

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2. What was it about you, the situation, and/or the system of CEMD that inspired this peak experience to emerge? What did you learn from this experience?

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3. What do you appreciate most about Confidential Enquiries into Maternal Deaths?

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4. What do you value most about yourself as a member of the CEMD? What excellence do you bring into the CEMD?

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5. What is the one thing that gives life to Confidential Enquiries into Maternal Deaths, without which this system would just not be the same?

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INVITING THE EXTRAORDINARY

In the phase of global escalation in maternal deaths and a call for reduction of maternal mortality by 75% by 2015 (MDG5) the success of an effective CEMD system is dependent on their collective capacity to invite the extraordinary. When we are at our best, we invite the extraordinary by creating new ways of doing things and by utilizing extraordinary communication strategies to find new and different solutions. We invite the extraordinary by exploring and taking risks; by being inquisitive and by looking at things in new and different ways. We invite the extraordinary by serving as a conduit for new ideas and by boldly inventing new ways of engagement that establish new standards for excellence in our systems.

[**select the appropriate area in which you serve within the CEMD*]

6. Tell me about the best [facility maternal mortality review/ maternal death assessment/ computation of maternal death results]* you have attended. What was it about that session that made it so effective?

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7. Tell me about a case where the team successfully [reviewed/assessed / computed the results]* in a positive way. What did you do right? Be specific

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8. What do you appreciate most about the members of your team?

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9. What is done to make them feel that they are an important part of the of the CEMD system?

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10. What do you appreciate most about the other stakeholders of the CEMD system? [Facility Maternal Mortality Review Teams, Maternal Death, Assessors, LCCEMD, Policy makers (MOH)]

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11. Tell me what you do when you feel highly relaxed, most secure, or most cherished in your work? –when it is simply great to be together.

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12. What makes the CEMD so unique and exceptional? What do you see as the unique qualities of this system?

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13. Share the highlight of your work in the CEMD – a time when you have felt most effective and when your contribution meant most to you and the people around you.

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14. What do you regard to be the best aspect or attribute of the CEMD; the aspect or attribute you appreciate most?

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IN CLOSING

Imagine that you have a magic wand, and you would have any three wishes granted in order to create an ideal CEMD; what would those wishes be? (Please – THINK BIG)

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INTERVIEW SUMMARY SHEET

Individual exercise

What were the best stories/quotes that you heard in the interview? Summarise your thoughts below.

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POSITIVE THEMES OF OUR CEMD

Voting with six stickers per person.

The themes that represent the positive core of our system of CEMD.

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DREAM

DREAM EXERCISE

It is five years from now. You are a member of an effective and ideal CEMD system. What do you see as marvellous about this system? What has changed? Who brought about the change? What was your contribution in it?

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VISUAL IMAGE OF AN EXTRAORDINARY CEMD

(A collage)

DESIGN

Provocative proposition about the CEMD

Write down a single line statement that describes your system of CEMD in an optimal way. This will be the statement of possibility (provocative statement).

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To write a good provocative proposition, capitalize on the opportunities discussed previously, and ask yourself the following questions:

- Is it provocative? Does it stretch and challenge?
- Is it desired? Do we want it as a preferred future?
- Is it stated in affirmative bold terms?
- Is the phrase catchy?

Creating and sustaining our dream

SOCIAL ARCHITECTURE

What are the desired resources/frameworks for meeting the opportunities identified in the dream exercise?

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DESTINY

Actions/ideas to operationalize the themes identified in the discovery phase

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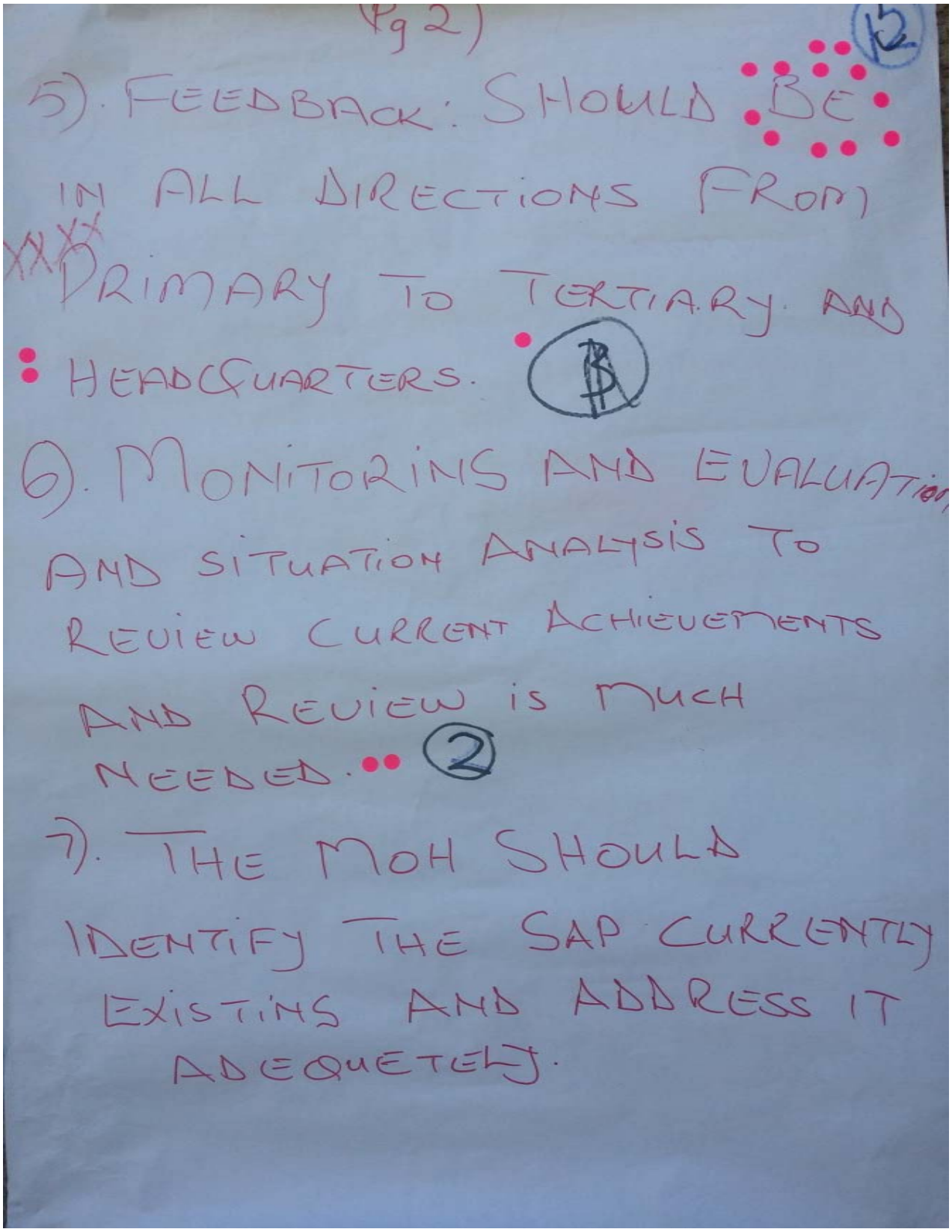
ANNEXURE G: A COMPLETED AI PROTOCOL

ANNEXURE H: SAMPLE OF VOTING



(Pg3)

8) THE MOH TRAINED TRAINERS FOR BESSEMINATION OF INFORMATION HENCE PROMOTINS SAFE MOTHERHOOD.

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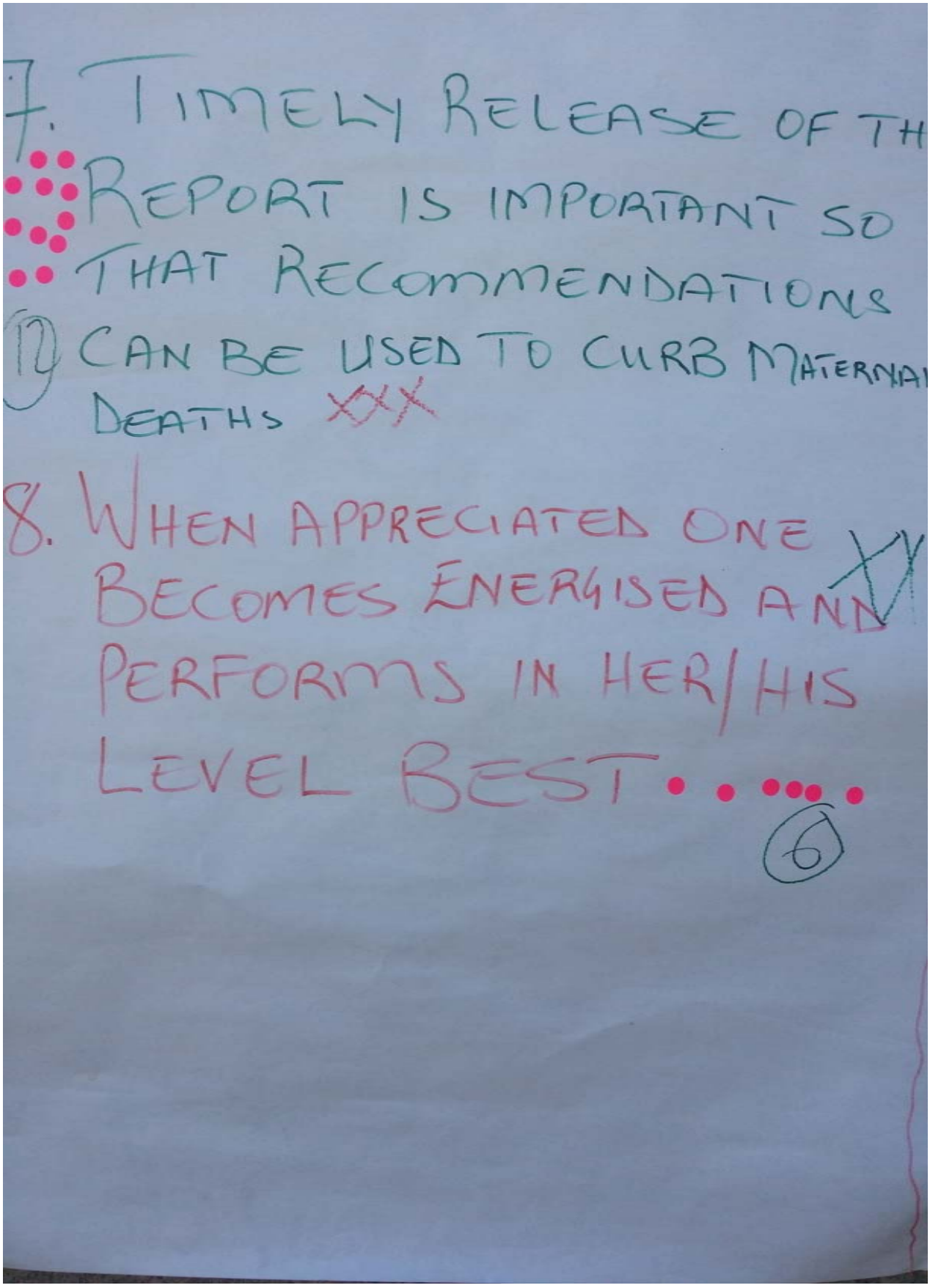
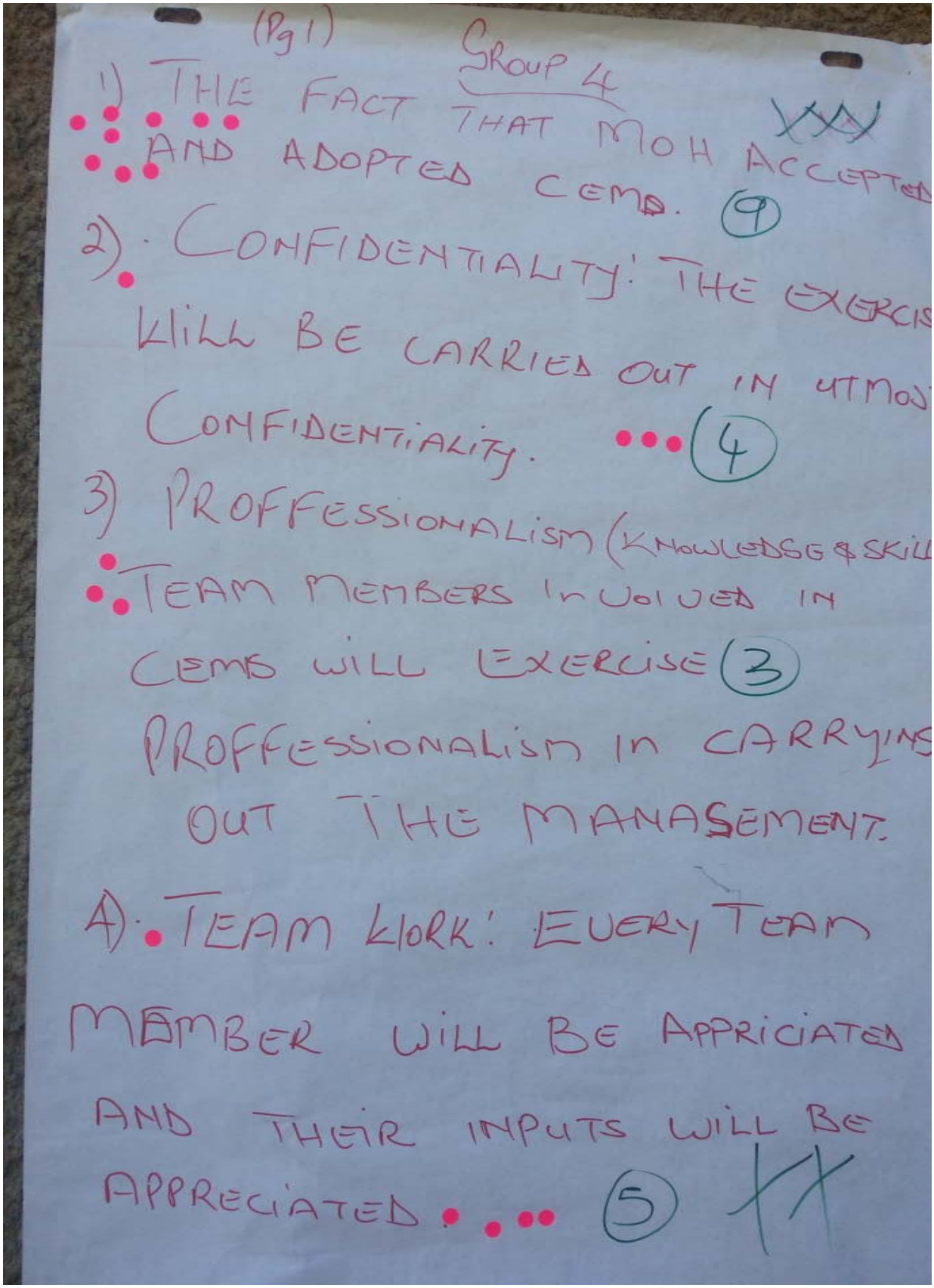

7. TIMELY RELEASE OF TH
REPORT IS IMPORTANT SO
THAT RECOMMENDATIONS
CAN BE USED TO CURB MATERNAL
DEATHS
8. WHEN APPRECIATED ONE
BECOMES ENERGISED AND
PERFORMS IN HER/HIS
LEVEL BEST


(Pg 1)

GROUP 4

1) THE FACT THAT MOH ACCEPTED AND ADOPTED CEMS. (9)

2) CONFIDENTIALITY: THE EXERCIS WILL BE CARRIED OUT IN UTMOS CONFIDENTIALITY. (4)

3) PROFFESSIONALISM (KNOWLEDGE & SKILL TEAM MEMBERS INVOLVED IN CEMS WILL EXERCISE (3) PROFFESSIONALISM IN CARRYING OUT THE MANASEMENT.

4) TEAM WORK: EVERY TEAM MEMBER WILL BE APPRICIATED AND THEIR INPUTS WILL BE APPRECIATED (5)