

Strengthening regulation of traditional midwifery practice in Lesotho

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It all starts here TM



PREFACE

Lesotho's Ministry of Health has discontinued training of traditional midwives and does not encourage home deliveries to continue. However, women, continue to use traditional midwives' services. Although traditional midwives render valuable services in their communities, they might also endanger the lives of their clients (women and babies) if they lack knowledge, skills and/or resources. This study confirmed that a need exists to regulate and control traditional midwifery practice in Lesotho according to the perceptions of interviewed traditional midwives, the registered nurses supervising the traditional midwives' practice and members of the Lesotho Universal Medicine Men and Herbalist Council.

This study was approved by the Health Research Ethics Committee (HREC) of the Potchefstroom campus of the North West University.

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DECLARATION

I declare that the dissertation entitled: **Strengthening regulation of Traditional midwifery practice in Lesotho** is my own work; and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references; and that this work has never been submitted before for any degree at any other institution.

Flavia Moetsana-Poka

Date

SUMMARY

The aim of this study was to formulate strategies that might strengthen the regulation of traditional midwifery practice in Lesotho. Such systems could promote safe traditional midwifery practice. Semi-structured interviews were conducted to identify and describe the perceptions of traditional midwives, registered nurses and members of the Lesotho Universal Medicine Men and Herbalist Council (LUMMHC), regarding the regulation of traditional midwifery practice in Lesotho.

The rationale underlying the study was to suggest strategies to strengthen the regulation of traditional midwives to promote their accountability for client care offered in the hard-to-reach areas where professional health care is limited.

Semi-structured individual interviews were conducted (until data saturation had been reached) with 12 traditional midwives, nine registered nurses and five members comprising the Lesotho Universal Medicine Men and Herbalist Council. Content analysis of the data was done independently by two coders who reached consensus about the identified themes and categories.

The research objectives were to identify:

- and describe the perceptions of traditional midwives, members of the Lesotho Universal Medicine men and Herbalist Council, and registered nurses regarding the regulation of traditional midwifery practice
- strategies that could be used to regulate traditional midwifery practice in Lesotho.

The first theme was described as the perceptions of traditional midwifery practice, including the categories: positive and negative perceptions of all the role players who took part in the study. The second theme addressed the perceptions of roles of other role players to improve the practice of traditional midwives, including the following categories: role of registered nurses, role of the Lesotho Universal Medicine Men and Herbalist Council and the role of other role players including traditional leaders and chiefs. The third theme addressed the perceived needs to improve the practice of traditional midwives, including categories: knowledge needs, physical needs, collaboration needs at local level and the need for regulation. The fourth theme described the perceptions of role players regarding the regulation of traditional midwifery practice, according to the combined perceptions of the three stakeholder

groups. The fifth theme described suggestions related to strategies regarding the regulation of traditional midwifery practice, including collaboration at government level, legislation, registration, licensing and certification; reporting, investigating instances of malpractice and holding disciplinary hearings. Each theme was discussed and compared with relevant data obtained from the literature. Conclusion statements of each theme were provided, and they served as a basis for the formulation of strategies that would assist in strengthening the regulation of traditional midwifery practice in Lesotho.

The research report finished with the conclusions, limitations and recommendations of the study for the Ministry of Health, the LUMMHC, for traditional midwifery practice and for further research.

Key concepts: midwifery in Lesotho, regulation, primary health care, traditional/cultural midwifery practices

VERSTERKING VAN REGULERING VAN DIE TRADISIONELE VERLOSKUNDE PRAKTYK IN LESOTHO

OPSOMMING

Die doel van die studie was om strategieë te formuleer ten einde tradisionele vroedvroue se reguleringstelsels in Lesotho te verbeter. Sodanige stelsels kan veilige tradisionele vroedvroupraktik bevorder. Semi-gestruktureerde onderhoude is gevoer om die persepsies van tradisionele vroedvroue, geregistreerde verpleegkundiges en lede van die Lesotho Universal Medicine Men and Herbalist Council, betreffende die regulering van tradisionele vroedvroupraktik in Lesotho, te identifiseer en te beskryf.

Die rationale onderliggend aan die studie was om strategieë voor te stel om die regulering van tradisionele vroedvroue te versterk en hulle verantwoordbaarheid vir kliëntesoorg te bevorder in die moeilike bereikbare areas waar professionele gesondheidssoorg beperk is.

Semi-gestruktureerde individuele onderhoude is gevoer (totdat data saturasie bereik is) met 12 tradisionele vroedvroue, nege geregistreerde verpleegkundiges, en al vyf lede van die Lesotho Universal Medicine Men and Herbalist Council. Inhoudsanalise van die data is onafhanklik gedoen deur twee kodeerders wat konsensus oor die geïdentifiseerde temas en kategorieë bereik het.

Die navorsingsdoelwitte was om:

- die persepsies van tradisionele vroedvroue, lede van die Lesotho Universal Medicine Men and Herbalist Council, en geregistreerde verpleegkundiges, aangaande die regulering van die tradisionele verloskunde praktik, te identifiseer en te beskryf
- strategieë te identifiseer wat benut kan word om die tradisionele verloskunde praktik in Lesotho te reguleer.

Die eerste tema beskryf die persepsies van tradisionele vroedvroupraktik, insluitende die kategorieë van positiewe en negatiewe persepsies van al die rolspelers wat aan die studie deelgeneem het. Die tweede tema het persepsies, aangaande die rolle van ander rolspelers, aangespreek om die praktik van tradisionele vroedvroue te verbeter, insluitende die volgende kategorieë: rol van geregistreerde verpleegkundige, rol van die Lesotho Universal Medicine Men and Herbalist Council, en die rol van ander rolspelers,

insluitende tradisionele leiers en hoofmanne. Die derde tema het die waargenome behoeftes om die praktyk van tradisionele vroedvroue te verbeter, aangespreek insluitende die volgende kategorieë: behoefte aan kennis, fisiese behoeftes, samewerkende behoeftes op plaaslike vlak en die behoefte aan regulering. Die vierde tema het die persepsies van rolspelers, aangaande die regulering van die tradisionele vroedvroupraktyk, aangespreek, volgens die gekombineerde persepsies van die drie belangegroepes. Die vyfde tema het voorstelle, betreffende die regulering van die tradisionele vroedvroupraktyk, aangespreek, insluitende samewerking op regeringsvlak, wetgewing, registrasie, lisensiëring en sertifisering, verslagdoening, ondersoek instel oor gevalle van wanpraktyk en die hou van dissiplinêre verhore. Elke tema is bespreek en vergelyk met toepaslike data wat uit die literatuur bekom is. Stellings met gevolgtrekkings is verskaf vir elke tema, en dit het gedien as basis vir die formulering van strategieë wat die regulering van die tradisionele vroedvroupraktyk in Lesotho kan versterk.

Die navorsingsverslag eindig met gevolgtrekkings, beperkings en aanbevelings van die studie vir die Minister van Gesondheid, die Lesotho Universal Medicine Men and Herbalist Council, die tradisionele vroedvroupraktyk en verdere navorsing.

Sleutelkonsepte: verloskunde in Lesotho, regulering, primêre gesondheidsorg, tradisionele/kulturele vroedvroupraktyke

LIST OF ABBREVIATIONS

AHWO	AFRICA HEALTH WORK FORCE OBSERVATORY
AIDS	AUTO IMMUNE DEFICIENCY SYNDROME
CHW	COMMUNITY HEALTH WORKER
DHMT	DISTRICT HEALTH MANAGEMENT TEAM
HIV	HUMAN IMMUNE DEFICIENCY VIRUS
HSS	HEALTH SYSTEM STRENGTHENING
ICF	INTERMEDIATE CARE FACILITIES
ICM	INTERNATIONAL CONFEDERATION OF MIDWIVES
ICN	INTERNATIONAL COUNCIL OF NURSES
LDHS	LESOTHO DEMOGRAPHIC HEALTH SURVEY
LMOH	LESOTHO MINISTRY OF HEALTH
LMOHSW	LESOTHO MINISTRY OF HEALTH AND SOCIAL WELFARE
LNC	LESOTHO NURSING COUNCIL
LUMMHC	LESOTHO UNIVERSAL MEDICINE MEN AND HERBALIST COUNCIL
MDG	MILLENNIUM DEVELOPMENT GOAL
MMR	MATERNAL MORTALITY RATE
MOH	MINISTRY OF HEALTH
PHC	PRIMARY HEALTH CARE
RN	REGISTERED NURSE
SSA	SUB SAHARAN AFRICA
SDG	SUSTAINABLE DEVELOPMENT GOAL

TBA	TRADITIONAL BIRTH ATTENDANT
UK	UNITED KINGDOM
UNFPA	UNITED NATIONS FUND FOR POPULATION ACTIVITIES
USA	UNITED STATES OF AMERICA
VHW	VILLAGE HEALTH WORKER
WHO	WORLD HEALTH ORGANIZATION

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CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION

Chapter 1 provides an overview of the study. The overview includes the introduction and the background of the study describing the rationale underlying the study. It further includes the problem statement, research objectives, the researcher's assumptions and the central theoretical statement of the study; and finally briefly describes the research design and methods, ethical considerations, and trustworthiness of the study.

Traditional midwifery plays a pivotal role in primary health care (PHC) in many developing countries, including Lesotho. Traditional midwifery, as a form of traditional health practice, has been in existence in all societies for centuries before modern medicine became prominent. Traditional midwives still deliver an estimated 60% of babies born in rural communities in developing countries, like Lesotho (Abodunrin *et al.*, 2010:78; Kaingu *et al.*, 2011:496; Lesotho Ministry of Health & Social Welfare (LMOHSW), 2011a:19). The role of traditional midwives (also called traditional birth attendants or TBAs) has been recognised as an important rich locally available resource. They play an important role in linking communities with health facilities and are an integral part of the PHC approach (Balasubramanian & Nirmala Devi, 2006:156; LMOHSW, 2011a:19).

Thatte *et al.* (2009:612) defined traditional midwives as traditional, culturally oriented and functioning independent of the health system, non-formally trained and community-based providers of care during pregnancy, childbirth and the postnatal period. Traditional midwives live traditional lives in villages, and use traditional medicines to provide care. They provide antenatal care, assistance during labour and delivery, and initial postpartum care. They are culturally respected and trusted by the community as counsellors for women during pregnancy and childbirth and for the care of new-born babies. Women and men confide in the traditional midwives and consult them throughout the course of the gestation period with pregnancy-related queries (Balasubramanian & Nirmala Devi, 2006:160-161; Kaingu *et al.*, 2011:495-496; LMOHSW, 2011a:8). These practitioners can be especially valuable in rural areas because they help community members care for the health of their families in their

respective settings whilst avoiding travelling long distances to health centres in remote areas (Balasubramanian & Nirmala Devi, 2006:160-161; Kaingu *et al.*, 2011:495-496; LMOHSW, 2011a:8; Thatte *et al.*, 2009:602). Organisations such as the United Nations Fund for Population Activities (UNFPA), the International Confederation of Midwives (ICM) and the World Health Organization (WHO) (2014:v), recommended that investing in midwives enables doctors, nurses and other health care professional cadres to focus on other health needs, and to contribute to reducing infections as well as preventable maternal mortality and neonatal death rates.

Despite the potentially valuable contributions of traditional midwives, they might pose challenges to the health care system, and regulation of this practice is weak and uncoordinated (Jali, 2009:47-59; LMOHSW, 2011a:38-43; LMOHSW, 2011d:12). The WHO (2013:34) reported that only 43.5% of their member states had legal statutes regarding the regulation of traditional midwifery practice. Although traditional midwifery is acknowledged by Lesotho's Ministry of Health and Social Welfare (Jali, 2009:44-45; LMOHSW, 2011a:18), there is no clear, well-defined regulatory framework that includes a code of practice, and minimum requirements for practice have not yet been established (LMOHSW). This study aims to explore and describe the perceptions of the important stakeholders regarding the regulation of traditional midwifery practice in Lesotho. The data-collection was done in one district out of the ten districts in Lesotho. The Berea district is considered to be typical of other districts, and the study findings will only apply in Berea district. This findings were used to formulate recommendations that may be applicable for the whole of Lesotho.

1.2 BACKGROUND OF THE RESEARCH

Lesotho has problems related to maternity and perinatal care. The maternal mortality ratio is 1 024 maternal deaths per 100 000 live births for the seven years preceding the current survey conducted during 2016. The UNFPA, ICM and WHO (2014:iii) report showed that 92% of all the world's maternal and new-born deaths and still births occur in 73 low and middle-income countries, including Lesotho. However, only 42% of the world's medical, midwifery and nursing personnel are available to women and new-born infants in these countries. Therefore, evidence has shown that the maternal mortality ratio (MMR) for Lesotho does not differ significantly from the one reported in the 2009 Lesotho Demographic Health Survey (LDHS in LMOHSW, 2016: 277). The infant mortality rate was 91 deaths per 1 000 live births in 2004 and 2009, before dropping to

59 deaths per 1 000 live births in 2014. Neonatal mortality changed little between 2004 and 2009 and declined in 2014. All three measures of mortality had improved from 2009 to 2014 (LMOHSW, 2016: 116). The 2016 LDHS indicates that institutional deliveries in Lesotho have increased from 52% in 2004 to 59% in 2009 and to 77% in 2014 (LMOHSW, 2016:123). Moreover, the UNFPA, ICM and WHO report (2014:5) further emphasised that 73 countries that completed the 2014 survey had made progress to reduce their maternal mortality ratios (MMRs), with an average annual rate of reduction of 3% since 1990. One reason for this progress is that many low-income countries have improved access to midwifery care. The UNFPA, ICM and WHO report (2014:5) and the 2016 LDHS (in LMOHSW, 2016:5) report recommended that more should be done to strengthen midwifery in order to come closer to (and eventually achieve) maternal survival targets and universal access to reproductive health. This is the case because home deliveries are still continuing; and are reported to be more common in rural areas and among less educated and poorer women.

Lesotho also has an inadequate number of registered nurses, and the staffing complement does not meet the minimum staffing requirements recommended by the WHO. Nurses in Lesotho are also trained as midwives. According to the WHO's minimum requirements, Lesotho with a population of approximately 1 889 661, needs at least 3 272 nurses to meet the standard of 1.73 nurses per 1 000 persons (LMOHSW, 2014:120). However, according to the Africa Health Workforce Observatory (AHWO) (2012:37), only 935 nurses were working in Lesotho's public sector health facilities in 2011. Therefore a ratio of nurses within the health sector was 0.49 per 1000 persons. Lesotho trains only 20% of the number of health professionals required to provide services at PHC level (LMOHSW, 2013:7; Lesotho National Decentralisation Policy, 2014:9).

Lesotho is divided into urban and rural areas, and topographically divided into four zones based on altitude: lowlands, foothills, mountains and Senqu River Valley (LMOHSW, 2012:1). About 75% of Lesotho's population lives in the mountainous rural areas where limited health facilities are available (LMOHSW, 2012:12). Due to the limitations of access to health facilities and the shortage of human resources, traditional midwives provide urgently needed midwifery services. Traditional midwives play significant roles in the lives of people living in the remote areas of Lesotho (Balasubramanian & Nirmala Devi, 2006:158; Jali, 2009:39-40). The LMOHSW has

recognised traditional midwifery as an integral part of the health care system, providing basic health care services at grass roots level. Traditional midwives link their communities with health facilities, reduce the burden of high maternal mortality rates and help to maximise the utilisation of available human resources in the health system (Kasilo & Trapsida, 2010:27; LMOHSW, 2010a:6; 2011a:18; 2014:7). The health care system in Lesotho has recognised the importance of traditional health practices, particularly traditional midwifery, similar to other Sub-Saharan African (SSA) countries.

Voluntary village health workers (VHWs), including traditional midwives, comprised an estimated 56% of the total of Lesotho's formal and informal personnel in the health sector in 2004. The VHWs provide the first line of contact for basic health care services in communities and at village health posts (LMOHSW, 2005:2; LMOHSW, 2012:22). In 2005, the report issued by the Lesotho Health Sector Human Resources Needs Assessment revealed that the health sector personnel's distribution was disproportionate to the population's distribution. Lesotho's central region had 2.04 personnel per 1 000 population, whilst the northern region had 1.33 and the southern region had 1.13 (LMOHSW, 2005:3). The Community Health Worker Policy has shown that Lesotho has approximately 5 639 VHWs (CHW Inventory, 2004), who are also referred to as Community Health Workers (CHWs), including traditional midwives (LMOHSW, 2012:2). There is no official record that clearly specifies the numbers of the trained traditional midwives in each district. This might be because the practice is not encouraged any longer.

The VHWs are trained by registered nurses working at PHC health centres to provide the first line of PHC (promotive and preventive health care services) in a cost effective manner at the community level. They also refer patients to higher level health centres for further management if necessary (LMOHSW, 2010b, 2011b). The training encompasses the performance of basic health assessments, providing initial treatment, supplying first aid services and home-based care, monitoring growth, promoting maternal and child health care, community-based rehabilitation of the disabled, and maintenance of a village register (LMOHSW, 2011b:8-9; 2012:11). The training lasts for two weeks at a health centre or in a village. The initial training is followed by refresher courses and monthly meetings where relevant topics are discussed with the VHWs' supervisors (LMOHSW, 2011b:8). However, according to the LMOHSW (2011d:6), the LMOHSW is no longer recruiting and training new traditional midwives in Lesotho.

Where they still exist, their function is to refer women to deliver at health centres or hospitals. Even though Lesotho is no longer recruiting traditional midwives, there is no policy framework formalising the WHO guidelines and the roles, responsibilities and the status of the VHWs. The organisation and practice of the traditional health sector function informally without a legal instrument to support the practice (LMOHSW, 2011a:21). The Lesotho Health System Strengthening (HSS) project (2012:2) also confirmed that the traditional healers are not formally included in the health service structure. Thus there might be different perspectives regarding the legality of the practice of the traditional midwives (including home births) because these issues have not been formally addressed in legal documents.

The supervisors of the VHWs are registered nurses who work at the health centres, and they report to the District Health Management Team (DHMT), according to the Lesotho Health Policy (Lesotho HSS project, 2012:6-10; LMOHSW, 2011a:19; LMOHSW, 2011b:8). Supervision of VHWs of whom some are traditional birth attendants, includes providing follow-up training at health centres or in villages to help them to identify serious health problems in their communities and to solve such health problems. The registered nurses often visit the villages to assess and supervise the work of the VHWs and bring supplies for providing basic PHC services. During these visits, the registered nurses discuss the communities' health problems, accomplishments of VHWs, and make future plans. The registered nurses also collect records and information about health problems to compile statistical reports for the DHMT, which then forms part of the district report (LMOHSW, 2011a:13). Within each district, the district public health nurse, who is part of the DHMT, oversees activities of all health service providers in the district, and supervises hospitals and health centres within the district.

The contribution of traditional midwives was realised when Lesotho adopted the PHC approach of the Alma-Ata Declaration of 1978 during 1997, as a means of meeting the ideal of "health for all" (LMOHSW, 2012:22; WHO, 2009:3-9). The main focus of PHC is making health care accessible, affordable and acceptable to individuals and families in their communities through their full participation and at a cost that the community and country can afford (LMOHSW, 2011a:26; WHO, 2009:3). PHC is an important strategy to strengthen the health care system of the country and provides a practical approach for making health care services acceptable to community members (Jali, 2009:39; LMOHSW, 2011a:14). It also provides comprehensive health services (promotive,

preventive, restorative, curative and rehabilitative) to all. Lesotho adopted the PHC strategy to decentralise health services to the districts by creating a link between the district hospitals and the LMOHSW's headquarters (Lesotho National Decentralisation Policy, 2014:2-5).

To facilitate the implementation of PHC in Lesotho, new structures and approaches were introduced in 2011. One such new programme was the VHW program which was coordinated by the Family Health Division within the Department of PHC at the LMOHSW. The programme was initiated to enhance community participation, maximum self-reliance and improving accessibility of services (LMOHSW, 2010b, 2011b). The VHW worker programme includes the training of community members and practising traditional midwives as VHWs. The VHWs are selected by the communities they serve, with the approval of the local authorities, and should be mature adults and fulltime residents.

On the contrary with the traditional midwives and the VHWs within the health sector, the practising registered nurses and midwives in Lesotho are accountable for their acts and omissions to their employers and to the Lesotho Nursing Council (LNC) as the statutory body regulating their practice (Lesotho Nurses and Midwives Act, 1998:116-117). The LNC sets standards for nurses and midwives that outline their expected professional conduct; and they are held responsible to provide the best possible standard of care in a competent, safe, ethical and accountable manner (Lesotho Nurses and Midwives Act, 1998:106; LNC Code of Professional Conduct, 2013:4-6). Nursing personnel are also held accountable for the practice of the traditional midwives they train and supervise. The registered nurses reportedly experience challenges concerning the traditional midwives' practice when they disregard instructions, maltreatment occurs, or discrepancies in the management of home births occur and when referrals are delayed (LMOHSW, 2011a:11).

In Lesotho, the Lesotho Universal Medicine Men and Herbalist Council (LUMMHC) (1978:63-64) regulates, registers and licences traditional healers, but not traditional midwives although they can also be considered traditional healers. There are no clear guidelines outlining the legal responsibilities and expectations of traditional midwives; hence, no legal action can be taken if malpractices pertaining to their actions and omissions are reported. The Lesotho National Health Sector Strategic Plan (LMOHSW, 2012:11) has shown that even though there is a linkage between the LMOHSW and

traditional midwives, this linkage needs to be legally strengthened to safeguard the public's interests. Hence, there is a need to identify strategies that would help to strengthen the regulation of traditional midwifery practice to ensure accountability at all levels of care for safeguarding the public against malpractices (Balasubramanian & Nirmala Devi, 2006:170; LMOHSW, 2011a:22).

Limited recent literature relates to the regulation of traditional midwives. Jali (2009:44), Kasilo *et al.* (2010:9) and Kasilo and Trapsida (2010:26-27), have revealed that even though more than half of the African countries developed national policies on traditional medicine and regulation, only a few developed regulations for traditional health practices. Eighteen countries developed national codes of ethics to ensure the safety, efficacy and quality of traditional health practices. However, 21 countries also developed legal frameworks for the accreditation and registration of traditional health practitioners and the establishment of a traditional health practitioners' council for regulating these practices in a specific country.

Despite the establishment of the legal frameworks, non-regulation of traditional health practices still poses serious risks to the population. Lack of regulation in many countries implies that some unlicensed practitioners' "treatments" could have fatal consequences for community members, especially in rural areas (Kaingu *et al.*, 2011:499; Kasilo & Trapsida, 2010:28). The WHO (2013:30-40) also emphasised that there are challenges and opportunities in relation to national policies, laws and regulations, quality, safety and effectiveness of traditional midwifery practice. Many traditional midwives could be considered to practise outside the law. However, even where legislation prohibits certain practices or the activities of untrained practitioners, this is rarely enforced (Kaingu *et al.*, 2011:499; Kasilo & Trapsida, 2010:28).

Given the findings of various studies, it has been shown that traditional midwifery practice could contribute towards reducing the high maternal mortality rates in countries with limited resources, including Lesotho, considering issues of accessibility and shortage of skilled personnel in remote areas. Traditional midwifery practice does, however, need to be regulated to protect the health of mothers and babies.

1.3 PROBLEM STATEMENT

Traditional health practice (including traditional midwifery) is an important component of the health care system in Lesotho, plays a vital role in PHC and serves as a link between the national level (the LMOHSW) and the community level (Jali, 2009:40; LMOHSW, 2011a:28). However, there are no clearly defined mechanisms in place to regulate the practice of traditional midwives as compared to other health care providers in order to protect the public against unsafe and risky practices (Kabayambi, 2013:1; Kasilo & Trapsida, 2010:27-28). The traditional midwives are supervised by registered nurses in Lesotho. Traditional midwives' maltreatments and delayed referrals might contribute to the country's high maternal and perinatal mortality rates and pose challenges for the supervising registered nurses (Abodunrin *et al.*, 2010:78-79; Jali, 2009:40; Kityo, 2013:1-2; LMOHSW, 2012:12).

Limited research relates to the regulation of traditional practitioners (Chmell, 2012:140; Jali, 2009:46; Kasilo *et al.*, 2010:13; Kasilo & Trapsida, 2010:31; WHO, 2013:30-40). The WHO (2013:33) recommends a review of existing regulatory systems in order to develop standards to regulate traditional midwifery practice. Therefore, the researcher envisaged exploring perspectives of the important role players regarding the regulation of traditional midwifery practice in Berea district which is typical of the ten districts of Lesotho in order to strengthen the existing regulation and health systems at a district level, and thereby to enhance safe traditional midwifery practice.

1.4 RATIONALE UNDERLYING THE STUDY

Lesotho's MOH needs to harness all available resources to meet the health care needs of rural communities in a responsible manner. This necessitates ensuring that the health practitioners' roles are clearly defined within the existing legal frameworks, in order to strengthen health services at all levels.

Strategies to strengthen the regulation of traditional midwives might promote accountability of the traditional midwives for care provided in hard-to-reach areas where professional health care is inaccessible. These strategies might also reduce the liability of registered nurses to account for maltreatments or deaths of traditional midwives' clients. The LUMMHC should be strengthened to inform traditional midwives about best practices, and to enforce compliance with the strategies to be developed to address the

proper standards to guide traditional midwifery practice, and on how to discipline traditional midwives who provide unsafe care. Identified risky behaviours should be addressed during subsequent training sessions to avoid similar occurrences in future.

1.5 RESEARCH QUESTIONS

The following research questions flow from the background and problem statement:

- What are the perceptions of traditional midwives regarding the regulation of their practice?
- What are the perceptions of members of the LUMMHC regarding the regulation of traditional midwifery practice?
- What are the perceptions of registered nurses responsible for supervising traditional midwives regarding the regulation of traditional midwifery practice?
- Which strategies can be used to regulate traditional midwifery practice?

1.6 RESEARCH AIM AND OBJECTIVES

The following research aim and objectives guided the study.

1.6.1 Aim of the study

The aim of the research was to strengthen the traditional midwifery regulatory systems in Lesotho in order to enhance the effectiveness of regulatory mechanisms to promote safe practice.

1.6.2 Research objectives

In order to reach the aim of the study, the objectives of the study are to:

1. explore and describe the perceptions of traditional midwives regarding the regulation of their practice;
2. explore and describe the perceptions of members of the LUMMHC regarding the regulation of traditional midwifery practice;

3. explore and describe the perceptions of registered nurses responsible for supervising traditional midwives regarding regulation of their practice and
4. identify strategies that could be used to regulate traditional midwifery practice.

1.7 PARADIGMATIC PERSPECTIVES

The paradigmatic perspective is the accepted set of beliefs or values that guide the researcher (Guba & Lincoln, 2005:192; Klopper, 2008:67). In this study, the researcher's assumptions are based on the epistemological philosophy which deals with the nature of traditional and cultural practices, implying African traditional and cultural experiences (Botma *et al.*, 2010:38). The paradigmatic assumptions of this study include meta-theoretical, theoretical and methodological assumptions. The following statements define the paradigmatic perspective and parameters within which the researcher conducted the current study:

1.7.1 Meta-theoretical assumptions

Meta-theoretical assumptions refer to the researcher's beliefs about the human being, society, the discipline, and the purpose of the discipline as well as the general orientation about the world; and the nature of research, it is philosophical in nature and cannot be tested (Klopper, 2008:67; Botma *et al.*, 2010:187). The meta-theoretical assumptions of this research comprise human beings, experience, health, nursing and traditional health.

1.7.1.1. Human being

A human being is defined as a living, growing gestalt that possesses three spheres of being, that is the body, mind and soul, which are influenced by the concept of self (Alligood & Tomey, 2006:107). In this study, the human being is the health care provider delivering PHC services to the community in the villages, considered to be the grass roots level of Lesotho's health care system. In this study, the concept human being refers to the traditional midwives, the health centres' registered nurses and the members of the LUMMHC, representing the three target population groups of the current study.

1.7.1.2. Health

Health is a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity (Cookfair, 1996:147; Stanhope & Lancaster, 2004:249). The term 'health', as described in this study, refers to the community members who receive care rendered by the traditional midwives. Traditional health is connected to the beliefs, culture and traditions of the Lesotho population (known as the Basotho), and it is the first level of care which is used by the majority of Basotho for consultation in case of illness (Jali, 2009:15).

1.7.1.3. Nursing

Nursing is a theoretical system of knowledge which prescribes a process of analysis and action related to the care of the ill or potentially ill person (Kotze, 2008:16). Nursing is the scientific professional discipline which focuses on prevention, promotion and provision of care to the client/patient as an individual, family and community in all the health care settings (that is at primary, secondary and tertiary level). The registered nurses working at the health centres are responsible for supervising the VHWs at community level, and report to the DHMT (LMOHSW, 2011b:8; LUMMHC Act, 1978:62). The registered nurses are therefore held accountable for the practice of the traditional midwives in order to ensure the provision of safe care. In this research, nursing is the provision of care rendered to the clients/patients who have received the first consultation and assistance from the traditional midwives in their villages and were later referred to the health centres, without any report or documentation of the herbal treatment which had been given to the client. Nursing also provides training and supervision (indirect patient care) to the VHWs.

1.7.1.4. Traditional / cultural health care

Traditional/cultural health care is viewed as the traditional or cultural practices provided through the use of traditional practices and herbs in treating any illnesses to maintain persons' wellbeing and health (Jali, 2009:15; Kaingu *et al.*, 2011:496).

1.7.2 Theoretical assumptions

A theoretical assumption reflects on the valid knowledge in existing conceptual frameworks, and therefore includes the central theoretical argument and definitions of the key concepts of the study (Botma *et al.*, 2010:187).

1.7.2.1. Central theoretical statement

Exploring and describing the perspectives of traditional midwives, the members of the LUMMHC and the registered nurses responsible for supervising traditional midwives' practices, will contribute to the development of guidelines (minimum standards) on traditional midwifery practice in Lesotho. This will support the LUMMHC Act No. 17 of 1978 and therefore also the strategies to strengthen the regulation of traditional midwives.

1.7.2.2. Conceptual definitions of key concepts

The theoretical assumptions, addressed by the researcher in this study, are defined so that readers can share the researcher's meaning of key concepts used in this dissertation.

- Traditional midwife

The traditional midwife is a mature woman who is a village resident, she is a volunteer accepted by the public/community and well respected, trusted and renowned for her skills in performing home deliveries. She is not selected but identified by the public/community through her noble skills (Balasubramanian & Nirmala Devi, 2006:162; LMOHSW, 2011a:4). In this study, the researcher used the term traditional midwife instead of traditional birth attendant (TBA) because it was deemed to be more respectful towards the traditional midwives.

- Regulation

Regulation is defined as the systems or mechanisms whereby order, consistency, and control are brought to an occupation and its practice. It exists to assure standards of practice and to protect the public (Benton, 2007:6). In this study, regulation refers to the legal measures, derived from health legislation, to control traditional midwifery practices

and protect the public against risky traditional health practices rendered at community level.

The practice of traditional healers (excluding traditional midwifery practice) is regulated by the LUMMHC. This council is reflected as the body corporate, with perpetual succession and a seal, capable of suing and being sued and capable of carrying out its functions under the LUMMHC Act No. 17 of 1978. This council consists of not more than eleven officers appointed by the MOH (LUMMHC, 1978:62). Even though there are regulations pertaining to traditional health practices, they do not clearly specify the legal measures and processes to be followed in cases where traditional midwives are involved in alleged malpractice.

- Traditional health practice

Traditional health practice is the sum-total of all the knowledge and practices, whether explicit or implicit, used in the diagnosis, prevention and elimination of physical, mental or social imbalance relying exclusively on practical experience and observation handed down from generation to generation verbally and/or in writing (Jali, 2009:15). In this study, traditional midwifery practice is considered a specific type of traditional health practice used by traditional midwives to manage pregnancy, labour and postpartum care.

- Health centre

A health centre is the main formal sector provider/health care facility which offers PHC services, including health assessment, promotion, screening and health education (Stanhope & Lancaster, 2004:249). In Lesotho, a PHC specialised nurse, locally known as the nurse clinician, is in charge of the health centre (LMOHSW, 2005:9). Health centres are used as referral centres by the traditional midwives, and the registered nurses working at the health centres report to the public health nurse who is part of the DHMT located within its area of jurisdiction.

- Primary Health Care (PHC)

The main focus for PHC is making health care accessible, affordable and acceptable. It encourages community participation and promotes the maximum level of self-reliance. The WHO's Alma Ata Declaration (WHO, 1978) recognised PHC as a means of

achieving the goal of “health for all by 2000” and the contributions of traditional birth attendants in meeting the goal of health for all through PHC. Community health involves nursing care directed to meeting the needs of all groups of people at the community level. This is done by providing basic health care services by traditional midwives and community health workers in accordance with the PHC strategy (LMOHSW, 2011b:18; Stanhope & Lancaster, 2004:249).

1.7.3 Methodological assumptions

Methodological assumptions explain what the researcher believes good science practice should encompass (Botma *et al.*, 2010:188). The researcher believes that the scientific research process must be systematic, well-planned, ordered and reported in such a manner that the research community can have confidence in research outcomes which will improve the quality of health services and care to the benefit all the people concerned.

1.8 RESEARCH DESIGN AND METHODS

The research design and methods will be briefly introduced in this section, but will be discussed in more detail in Chapter 2.

1.8.1 Research design

In this study, an explorative, descriptive, contextual research design was used. The researcher used a qualitative approach to explore and describe the perceptions of the traditional midwives, the members of the LUMMHC and those of the registered nurses supervising traditional midwives' practice in Lesotho. An explorative design was suitable because limited previous research had been done on the regulation of traditional midwives in Lesotho. A qualitative description, according to Sandelowski (2010:78), was used because, although this study used a qualitative approach, it focused on a description of perceptions from three groups of participants (registered nurses, traditional midwives and members of the LUMMHC) and was neither a phenomenological nor a grounded theory study.

This study was contextual in nature because the results were to be specific to the context of Berea district which is one of the ten districts in Lesotho. The researcher did not intend to generalise the findings as the aim of this research was to specifically strengthen the regulation of traditional midwifery practice in Berea district. Even though the setting was Berea district, the researcher was aware that it is a national issue which needed to be addressed broadly, but due to limited funding and time limitations, it was not feasible for the researcher to address it at a national level.

1.8.2 Research methods and procedures

The methods congruent with the research design, used in this study, included decisions regarding the setting, study population, sampling process and methods used for data collection and analysis.

1.8.2.1. Setting

The setting refers to the place where the study takes place. The setting of the study was the Berea District, one of the ten rural districts in Lesotho which is typical to other districts as they experience similar challenges, even though the numbers of traditional midwives would differ in districts. In this district there are 836 villages (Lesotho Bureau

of Statistics, 2006). The researcher used the purposive sampling method to select four health centres and two villages that were within reach and used by the traditional midwives for their referrals, and also accessible for data collection (Burns & Grove, 2009:355; Botma *et al.*, 2010:201; Moule & Goodman, 2009:274).

The health centres were:

- Immaculate Conception Health Centre
- Pilot Health Centre
- Sebedia Health Centre
- Bethany Health Centre

1.8.2.2. Population and sampling

The target populations for the current study comprised 15 traditional midwives from two villages in the selected district, the 10 registered nurses who supervised the traditional midwives at the health centres and the five members of the LUMMHC. The LUMMHC office is centrally located, even though the members reside in various districts within Lesotho. All these stakeholder groups were required to comply with the selection criteria used as specified in chapter 2 of this study.

1.8.2.3. Data collection

The processes of gaining access to the participants, obtaining informed consent and the data-collection process are discussed in this section. The purpose of the study was to explore the perceptions of the stakeholder groups regarding the regulation of traditional midwifery practice. Semi-structured individual interviews (described in chapter 2, section 2.4) were conducted to collect data as this afforded the researcher an opportunity to gain insight into the social context of the research, which focussed on exploring the perceptions of the three stakeholder groups regarding the regulation of traditional midwifery practice (Creswell, 2009:175; Moule & Goodman, 2009:174; Sandelowski, 2010:80). The semi-structured interviews were recorded on audiotapes and transcribed verbatim for the purpose of content analysis. Field notes (descriptive, reflective and demographic field notes) were recorded by the researcher and the interview team during and after the interviews and integrated with the data from the transcribed interviews during data analysis (Botma *et al.*, 2010:205; Burns & Grove, 2009:529; Polit & Beck, 2001:384). Focus group interviews could also have been used but the

researcher decided to conduct individual interviews as it would have been difficult getting enough of the stakeholders together for a focus group because of their limited numbers. In most health centres there were only 3 – 4 registered nurses and the council members were only five in total.

1.8.2.4. Data analysis

Data analysis was conducted to reduce, organise and give meaning to the information obtained during the semi-structured interviews (Burns & Grove, 2009:44). After data-collection, the recordings on the audiotapes were transcribed verbatim to ease the process of content analysis as described by Creswell (2009:183-190). The process of data analysis is described in chapter 2. Some transcriptions were transcribed partly in Sesotho and English (Annexure I, J, K) as some of the registered nurses and the members of the LUMMHC responded to some questions in Sesotho because they were able to express themselves better in their original language. The interviews which were partly in English and Sesotho were analysed directly from Sesotho as the data-analysed were both Sesotho speakers to protect the scientific integrity as some of the meaning could get lost if translated from the original language use. Those transcriptions were checked and verified by the experienced independent interviewer who worked with the researcher before the data was analysed.

1.8.2.5. Role of the researcher

The researcher's role was to act as a research instrument, as a collector and interpreter of the data, and to have relevant qualifications and research experience in this field of research (Moule & Goodman, 2009:189).

After permission had been granted, appointments were made with participants who were handed letters providing the details of the study; measures to address ethical issues and a form for providing written informed voluntary consent (see Annexures E, F, G). A trial run interview was conducted in order to evaluate the researcher's interviewing skills and to test the practical aspects regarding the data collection process. The researcher worked with an experienced independent interviewer who took field notes (demographic notes, reflective notes and descriptive notes), whilst the researcher conducted the interviews. The interview team comprised of the researcher and an experienced additional interviewer who was present throughout the interviews with the

three stakeholder groups. The additional interviewer intervened where necessary as some of the participants might have felt intimidated by the researcher's senior position when conducting the interviews. The independent interviewer made the participants feel more relaxed and comfortable, and reassured them that the interviews conducted are not related to the researcher's work or position. The independent interviewer is a research expert in qualitative studies, and completed the Masters in Nursing studies.

The researcher transcribed the interviews herself and also analysed the data with an independent co-coder.

1.9 ETHICAL CONSIDERATIONS

Ethics involves the consideration of moral obligations that one ought to conform to, especially when the research involves human subjects whose rights need to be protected (Brink *et al.*, 2012:32). Ethical considerations refer to the protection of the participants' rights, obtaining informed consent and the institutional review process (Klopper, 2008:71). In this study the researcher had to adhere to the relevant ethical principles as the study involved human beings.

The following ethical considerations were taken into account during the planning of the study:

Ethical approval was obtained from the Human Research Ethics Committee of the North-West University (Potchefstroom campus) (NWU-00176-15-S1) and the Ministry of Health Research and Ethics Committee, Lesotho. The public health nurse of the Berea District and the chiefs of the two villages gave goodwill permission to collect data.

Voluntary, informed consent was obtained from participants in written format after the details of the study had been explained to them regarding the measures to ensure confidentiality, anonymity, protection from harm and benefits of participation. A more detailed description of the ethical considerations follows in Chapter 2.

1.10 TRUSTWORTHINESS

Trustworthiness refers to rigour whereby the researcher implements openness, relevance, epistemological and methodological congruence, thoroughness in collecting data, and consideration of all the data in the analysis process, and the researcher's own understanding (Burns & Grove, 2009:54). Trustworthiness of this research was ensured

by adhering to the criteria identified by Lincoln and Guba (1985) (cited by Botma *et al.*, 2010:232); including credibility, transferability, dependability and confirmability. A detailed description of the applications of these strategies is provided in chapter 2.

1.11 CHAPTER LAYOUT

Chapter 1: Overview of the study

Chapter 2: Research design and methods

Chapter 3: Presentation and discussion of research findings

Chapter 4: Conclusions, limitations and recommendations

1.12 SUMMARY

Chapter 1 dealt with an overview of the study as a way of providing background information to the study, the research problem, research objectives, the research design and methods, and the ethical considerations for the study. Chapter 2 will address the research design and methods.

CHAPTER 2

RESEARCH DESIGN AND METHODS

2.1 INTRODUCTION

Chapter 1 presented an overview over this study. This chapter deals with the “how part” of this study detailing the research methods used in this study with reference to research design, population, sampling techniques, data collection and analysis, as well as the measures taken to comply with the principles of ethics and trustworthiness.

2.2 RESEARCH DESIGN

The research design refers to the plans and procedures for research that span the decisions from broad assumptions to detailed methods of data collection and analysis. The research design is also described as the blueprint for conducting the study (Burns & Grove, 2009:218; Creswell, 2009:3). The research design guides the researcher in planning and implementing the study in a way that is most likely to achieve the intended goal by answering the research question.

An explorative, descriptive, contextual qualitative research design was chosen because the researcher wanted to explore and describe the perceptions of the traditional midwives, the members of the LUMMHC, and of the registered nurses supervising traditional midwives, regarding the regulation of traditional midwives’ practice in Lesotho. Limited knowledge was available about this topic. Qualitative description, according to Sandelowski (2010:78), was used because this study used a qualitative approach focussing on a description of perceptions about the regulation of traditional midwifery practice, from three groups of participants. Consequently this was neither a phenomenological nor grounded theory study.

Exploratory research is used to develop an initial rough understanding of a phenomenon, and to explore its relevance where little is known about the phenomenon. An exploratory study is designed to increase the knowledge of the field of study (Botma *et al.*, 2010:50; Burns & Grove, 2009:359). The exploratory nature of this study gave the researcher an opportunity to explore the participants’ perceptions by asking questions regarding the regulation of traditional midwifery practice in Lesotho.

According to Burns and Grove (2009:44; 237), the purpose of descriptive research is to describe the phenomenon in real life situations and to understand the phenomenon under study. For the purpose of this study, the researcher described the participants' first hand perceptions about the regulation of traditional midwifery practice. Their perceptions were described in their own words, as portrayed in chapter 3.

This study was also contextual in nature because the results are specific to the context of the Berea District in Lesotho. The researcher did not generalise the findings as the aim of this study was to specifically strengthen the regulation of traditional midwifery practice in Lesotho.

Qualitative research refers to a means of exploring and understanding the meaning individuals or groups ascribe to social or human problems, involving emerging questions and procedures, data typically collected in the participants' setting, data analysis inductively building from particulars to general themes, and the researcher making interpretations of meaning of the data (Creswell, 2009:4; Moule & Goodman, 2009:174). Based on the purpose of this study, and in order to achieve its objectives, an explorative, descriptive, contextual, qualitative design was regarded as being appropriate.

2.3 RESEARCH METHODS AND PROCEDURES

Research methods refer to the techniques the researcher uses to organise and structure a study in a systematic manner. It includes data gathering, data analysis and ensuring rigour in research (Botma *et al.*, 2010:199; Polit & Beck, 2001:731). The research methods applied in this study are described in terms of the setting, population, sample, data collection, data analysis and the incorporation of literature.

2.3.1 Setting

The setting refers to the place where the study was conducted (Brink *et al.*, 2012:59). As indicated in the background of this study, the setting of this study was Berea District which is one of the ten rural districts. Berea District was selected because it is a typical rural district with mountains and foothills, and has practising traditional midwives. Berea District has 836 villages with a population of 760 717, and falls within the northern region which is served by 1.33 health personnel per 1000 population (Lesotho Bureau of Statistics, 2006; LMOHSW, 2005:3). Berea district has 18 health centres and four

hospitals; one is a government (public) hospital, whilst the other three are private hospitals. The health centres are not evenly distributed as most health centres are in town. Most villages are in remote areas that are inaccessible by road. It is difficult to reach the health centres from many villages, because of poor road infrastructure and having to travel long distances to reach health centres. Most of the traditional midwives practice in the remote villages, and thus their total number is difficult to estimate.

The researcher purposively selected the villages where knowledgeable and experienced traditional midwives were practising. The nurses in charge of the health centres assisted the researcher to identify four of the villages where traditional midwives conducted home deliveries and referred clients to health centres (Botma *et al.*, 2010:20; Brink *et al.*, 2010:134; Burns & Grove, 2009:355; Creswell, 2009:178). Four villages were selected.

To select the health centres, the researcher used a purposive sampling method to select the health centres located in the Berea district because they are used by the traditional midwives for referrals and were within reach and accessible. The public health nurse working at the Berea DHMT assisted the researcher to select the four health centres which were accessible for collecting data.

2.3.2 Population

The population is referred to as all elements (individuals, objects or substances) or aggregation of cases that meet certain criteria for inclusion in a given universe (Botma *et al.*, 2010:200; Burns & Grove, 2009:343). In this study, the target population comprised of at least 15 traditional midwives from the four selected villages, 15 registered nurses from the four selected health centres and 5 members of the LUMMHC.

2.3.3 Sampling

A sample is referred to as a subset of a larger set of the population that is selected by the researcher to participate in a research study. The researcher used the eligibility (inclusive and exclusive) criteria as specified below to identify the participants of the three stakeholder groups for this study (Brink *et al.*, 2012:132; Burns & Grove, 2009:361).

For this study the researcher used purposive sampling to select traditional midwives, registered nurses and members of LUMMHC who were knowledgeable about traditional midwifery in Lesotho. A total of 12 traditional midwives, nine registered nurses and all five members of the LUMMHC comprised the sample of the study because data saturation was reached when the interviews with these participants had been conducted. All five LUMMHC members were included in the study, implying that the population of LUMMHC members were interviewed (Botma *et al.*, 2010:201; Burns & Grove, 2009:355; Moule & Goodman, 2009:274).

- **Eligibility criteria**

The eligibility criteria used for this study included all participants that could speak and understand Sesotho or English as the semi-structured interviews were conducted in these two languages. Only participants who granted voluntary written consent and who agreed that the interviews could be audio recorded were interviewed.

Traditional midwives had to be aged 35 to 55; with a minimum of five years' experience of practising traditional midwifery because they would have had sufficient experience to be knowledgeable about the practice and the legal status of traditional midwives in Lesotho. Traditional midwives who were not practising traditional midwifery at the time of conducting the interviews were excluded because they might not have been knowledgeable about the current practice and legal status of traditional midwives. They had to practice in one of the four selected villages.

Registered nurses had to be working at the selected health centres within the Berea District, which was used by traditional midwives for referral of their clients; qualified midwives; directly involved in supervising traditional midwives; with at least five years' experience of working with traditional midwives. Registered nurses working at the DHMT level were excluded because they did not work directly with traditional midwives.

Members of the LUMMHC were experienced in keeping and maintaining registers of traditional healers. Thus all five LUMMHC members were interviewed although one member had less than five years' experience of serving on this council.

2.4. RESEARCH INSTRUMENTS

Semi-structured interviews were conducted with three groups of stakeholders, namely traditional midwives, registered nurses supervising traditional midwives' practice and members of LUMMHC.

2.4.1 Interview schedule for traditional midwives

The central questions posed to the participants were:

- Can you please tell us your experiences regarding the Lesotho Universal Medicine Men and Herbalist Council's current systems regarding regulation of traditional midwifery practice in Lesotho?
- Can you tell us your perceptions about the roles of the Lesotho Universal Medicine Men and Herbalist Council towards patient safety when providing traditional midwifery services?
- What actions are taken by the Lesotho Universal Medicine Men and Herbalist Council in cases where there has been any kind of mismanagement or putting a patient's life at risk during provision of traditional midwifery care?
- How can regulation help to improve traditional midwifery practice in order to promote safe care?

Interview schedule translated in Sesotho:

- Ke kopa u ko re qoqele ka litsebo tsa hau malebana le ts'ebetso ea lekhlotla la lona la Lesotho Universal Medicine men and Herbalist Council hore na lits'ebeletso tsa bona li joang malebana le ho laola tsebetso ea bapepisi metseng ka hare ho naha ea Lesotho?
- Ke kopa u re joetse maikutlo a hao malebana le boikarabello boo lekhlotla la lona la Lesotho Universal Medicine men and Herbalist Council le lokelang ho bo etsa malebana le ts'ebetso e sireletsehileng ea bapepisi metseng?
- Ke mehato efe eo lekhlotla la Lesotho Universal Medicine Men and Herbalist Council le e nkang malebana le ts'ebeletso e bohlasoa mosebetsing oa lona bapepisi metseng, e behang bophelo ba mokuli tsietsing?
- Ke kopa u ko re joetse maikutlo a hao hore na u bona eka ke lintho life malebana le taolo ea bapepisi metseng, e ka etsoang ho thusa ho ntlafatsa ts'ebetso ea bapepisi le polokeho ea sechaba.

The interviews with the traditional midwives were conducted in Sesotho because that is the official language they are most fluent in, and because of their low level of education (Annexure I). In order to ensure that credibility was maintained, the translation was checked by a language editor that is fluent in both English and Sesotho.

2.4.2 Interview schedule for registered nurses

- Can you please tell us about your perceptions regarding the regulation of traditional midwifery practice in instances where there have been reported malpractices from the community?
- Are there any legal actions taken against a traditional midwife with a reported malpractice? If yes, what kind of actions are taken, and by whom?
- What are the responsibilities of the traditional midwives towards providing safe patient care?
- What do you think are the strategies/approaches that could be taken to strengthen the regulation of traditional midwifery practice?

The above interview questions were not translated in Sesotho because all the registered nurses were fluent in English as their work language. Some registered nurses responded partly in Sesotho because they expressed themselves better. These interviews were analysed directly from Sesotho to protect the scientific integrity, as some of the meaning could get lost if translated from the original language used. Both data analysts were Sesotho speakers. An original transcript is included in Annexure J, and other original transcripts will be availed for readers to check should they wish to do so.

2.4.3 Interview schedule for members of the Lesotho Universal Medicine Men and Herbalist Council

- Can you please tell us about your role regarding the regulation of traditional midwifery practice, and any legal mechanisms you have in place?
- What action is taken in situations where any kind of traditional midwifery malpractice has been reported?
- What do you think are the strategies/approaches that could be used to strengthen the regulation of traditional midwifery practice by ensuring that patient safety is met at all times, and proper action is taken against those with reported malpractices?

The above interview questions were also not translated in Sesotho because all the members of the LUMMHC were fluent in English as their official language. Again some of these participants responded partly in Sesotho because they expressed themselves better. Just as with the interviews with registered nurses who prefer to answer in Sesotho, these interviews were also analysed directly from Sesotho. An original transcript is included as Annexure K of this dissertation, and other original transcripts are available.

The central questions for each stakeholder group were followed by probing questions, depending on the participants' responses to encourage further communication and facilitate the flow of information. The perceptions on what regulation by the LUMMHC should entail could have been addressed, but it was not at the level of their background.

2.5. DATA COLLECTION PROCEDURE

Data collection refers to precise, systematic gathering of information relevant to the research purpose or the specific objectives, questions, or hypothesis of a study (Burns & Grove, 2009:337). In this study, data were collected from the selected candidates who met the selection criteria of the study population. Individual semi-structured interviews were deemed to be a suitable data-collection method because it allowed the researcher to gain insight into the real social context of the research and to get in-depth responses enabling the researcher to seek greater clarity from the interviewees' responses. (Creswell, 2009:175; Moule & Goodman, 2009:174; Sandelowski, 2010:80).

2.5.1 Recruitment of participants

Recruitment is referred to as the process of obtaining participants for a study that includes identifying potential participants, approaching them to participate in the study, and gaining their acceptance to participate (Burns & Grove, 2009:363).

In this study, the following recruitment process was used for the different stakeholder groups:

- **Traditional midwives**

Before recruiting traditional midwives, the researcher first sought permission from the local village chiefs (gatekeepers), to gain entrance into the selected villages and health centres.

The researcher requested assistance from the public health nurse, working at the DHMT. This public health nurse, who supervises the health centres, informed the nurses in charge of the health centres about the study and identified leaders of the traditional midwives. These identified leaders were asked to act as mediators to assist with the recruitment of traditional midwives willing to participate in the study. Local mediators were used in each village.

- **Registered nurses**

The researcher requested assistance from the district public health nurse to consult with the nurses in charge of the health centres to be mediators and assist with the recruitment of participants (Botma *et al.*, 2010:201).

- **Members of the LUMMHC**

The researcher requested the chairman of the council to act as a mediator with the recruitment of the other four members of the council to participate in the study.

2.5.2 Obtaining informed consent

Before conducting research and after the proposal had been approved by the scientific committee of INSINQ research focus area, the researcher applied for ethical approval from the Human Research Ethics Committee (HREC) of the Faculty of Health Sciences of the Potchefstroom Campus of the North-West University. After approval had been granted (see Annexure A), the researcher requested permission to conduct the study from the Director General of Health, at the LMOHSW, in Lesotho (Annexure B).

After obtaining permission from the LMOHSW (see Annexure C), the local chiefs of the selected villages were requested to grant permission to enter the villages and to conduct interviews with the selected traditional midwives (see Annexure B). The Director General of Health Services and the chairperson of the National Health Institutional Review Board granted permission to conduct research (see Annexure C). The researcher and the experienced independent interviewer met with the local chiefs and the public health nurse separately. The researcher explained the details of the study including the participants' rights to confidentiality, anonymity, protection from harm; and their right to give consent at own will or refuse to give consent.

Copies of the informed consent forms approved by the Human Research Ethics Committee (HREC) of the Faculty of Health Sciences of the Potchefstroom Campus of the North-West University were made available to the traditional midwives, registered nurses and the council members. Each consent form was at the appropriate cognitive level for the target group. Consent forms for the traditional midwives were prepared in English and Sesotho because they were not all fluent in English; and the consent form for registered nurses and the council members were prepared in English only because they are fluent in English (see Annexures E, F, G).

After obtaining approval from the local chiefs, the researcher and the independent interviewer met the potential participants. The researcher explained the purpose of the research, its significance, benefits, and any risks which could result from participating in the study, and further informed them that all information would be treated confidentially. The potential participants were also informed that their decision to give consent was voluntary, and if they decided to withdraw from the study, they would not be punished or discriminated against in any way and their decision would not interfere with the study or their practice. The potential participants were allowed time to ask questions, and had a day to decide whether or not to participate in the study.

Participants who were satisfied with the information provided, signed two copies of the informed consent form which were co-signed by the researcher and the experienced independent interviewer (Botma *et al.*, 2010:15-23; Burns & Grove, 2009:529). One copy was for the interview team and the other for the participant. Illiterate persons were requested to sign with their thumbprint/initial that they understood the explanations. A witness was then asked to sign with them to confirm that they had made their mark willingly. The participants were informed about the contact details of the researcher as

well as of the office of the HREC of the North-West University which appeared on the consent form so that they could contact the researcher or the university if they had any questions regarding the study.

The researcher followed a similar process to obtain informed consent from the registered nurses and from the members of the council.

2.5.3 Conducting semi-structured interviews

The interview team comprised of the researcher and another experienced interviewer. The additional interviewer intervened where necessary as some of the potential participants might have felt intimidated by the researcher's senior position when conducting the interviews. The competence of the interviewers was assured through the training at the North-West University and a pilot interview that was conducted at an initial stage and evaluated by the study supervisor. After conducting the first interview which was voice recorded, the verbatim transcriptions and the field notes were prepared and evaluated by the study supervisor before allowing the team to continue with the rest of the interviews, which were then conducted in June/July 2016.

For the interviews with the traditional midwives, the interview team demonstrated respect for the participants' culture, traditions and beliefs by wearing traditional attire known as a "seshoeshoe" dress. The interviews were conducted in two of the four selected villages and the traditional midwives of the other two villages came to the villages where the interviews were conducted. The interview team used a rondavel (a round hut with a thatched roof) at one of the homes of the traditional midwives to conduct the interviews with the traditional midwives. The traditional midwives arrived very early for the interviews and were excited to take part in the study. They waited outside the yard in the warm weather while awaiting their turn to be called for the interviews. The interview team ensured that the house was comfortable, well ventilated, and free from any disturbances or interruptions to enable smooth communication and recording of the interviews.

The interviews with the registered nurses were conducted in suitable office at each of the two selected health centres. The researcher together with the nurse in charge of the centre prepared the office to ensure that it was quiet, safe and distant from any interruptions by clients, nurses or daily duties/operations. The interviews were very

successful as there were no interruptions and the schedule was well planned because the nurses took turns to be interviewed.

The interviews with the members of the Council were conducted at the LUMMHC office in Maseru district, which proved to be a quiet, safe and conducive environment and no disturbances occurred during the interviews.

Each interview lasted 30-45 minutes to obtain an in-depth understanding of participants' perceptions. The interviewer allowed the participants to take breaks whenever they wished to do so, to avoid exhausting them. All the participants were provided with snacks and transport fare where relevant after the interviews.

On completion of each interview, the researcher thanked the participants and attended to the questions participants had. They were also informed that the report of the research findings would be shared with them in the form of a presentation at the end of the research project.

The semi-structured individual interviews were recorded on audiotape (with the knowledge and permission of the participants) as a record of the conversation (Creswell, 2009:174) and to ease the verbatim transcription of each interview for the purpose of data analysis.

2.5.4 The use of field notes

During and after each interview, the interview team compiled the field notes regarding the observations of events and activities that might contribute to the richness of the data (Creswell, 2009:172). In this study, the following three types of field notes were used (Creswell, 2009:181-192):

- Descriptive notes, including the description of the physical setting, the dialogue and the events or activities of the participants (Botma *et al.*, 2010:218).
- Reflective notes, consisting of methodology notes, reflecting the methods and strategies, theoretical notes where the researcher attached meaning to the observations and personal notes which report the feelings and perceptions of the researcher (Polit & Beck, 2001:406-407).
- Demographic notes specifying the time, place and date; and demographic information about the participants (Creswell, 2009:181-192).

Field notes were integrated with the data from the transcribed interviews during data analysis.

2.6 DATA ANALYSIS

In this study, after data-collection, the recordings were first transcribed. The researcher transcribed the interviews herself. The transcriptions of the interviews conducted partly in Sesotho and English were analysed directly from Sesotho as the researcher is also a Sesotho speaker to protect the scientific integrity, as some of the meaning could get lost if translated from the original language used. Examples of the original transcripts are available in Annexures I, J and K.

Data analysis is conducted to reduce, organise and give meaning to data (Burns & Grove, 2005:732). In this study, the researcher used Tesch's steps according to Creswell (2009:183-190), as a data analysis plan.

The data analysis was done by the researcher and an experienced co-coder to ensure trustworthiness. The co-coder was an independent person experienced in qualitative research and data analysis. The co-coder was provided with a data analysis plan and copies of the recordings, transcriptions and field notes.

Both the coders had to independently listen to the recordings while reading through the transcriptions, integrate the field notes and then analyse semi-structured individual interviews.

The following data analysis plan was used:

- During the first step, the researcher and the co-coder independently organised and prepared for data analysis by reading through the verbatim transcriptions as soon as they became available to get a general sense of the information and reflect on its meaning. The field notes were typed and arranged to be linked to the relevant source of information; the notes and ideas were written in the printed pages' margins.
- In step two, the researcher and co-coder coded the data into chunks; derived meaning from the available information
- In step three, the data which related to each other were grouped into categories. Each category was organised according to topics which were marked with codes.
- In step four, the two coders generated a description of ideas and themes into the categories. Themes were analysed for each individual case and shaped into a general description. The themes displayed multiple perspectives from the participants and were supported by the diverse quotations and specific evidence.
- In step five, the researcher and co-coder used narrative passages and tables as adjuncts to the discussion, to convey the findings of the analysis. This included the detailed discussions of multiple perspectives from individuals' quotations.
- In step six, the researcher and co-coder interpreted the meaning of the data based on their own experiences and existing literature of other health professionals pertaining to the strengthening of the regulation of traditional midwifery practice in Lesotho (Botma *et al.*, 2010:224-226; Creswell, 2009:185-190).

In this study, the researcher and the co-coder independently analysed the transcribed data against the recordings and the field notes with the use of the analysis plan. The independent co-coder increased the reliability of the coding (Creswell, 2009:191). The researcher and the co-coder met to reach consensus after they had independently completed the analysis to enhance trustworthiness. During the meeting they discussed whether the themes developed from the interviews were true reflections of the deliberations the interviewers had with the participants, and to determine its accuracy (Botma *et al.*, 2010:231).

Peer debriefing was also used to increase trustworthiness. Peer debriefing refers to a session held with one or more colleagues to review and explore various aspects of the inquiry such as raw data and data reduction products to check whether the data findings are credible. The peer reviewers used were the educators at one of the nursing

education institutions in Maseru, Lesotho. The peer reviewers recommended that the data collected provided a true representation of the participants' views as it was accurately documented on transcribed verbatim and field notes, and matched with the audiotapes.

2.6.1 Integration of data with literature

After the data analysis had been completed, being organised and reduced into patterns and themes, literature was explored, interpreted and integrated with the collected data in order to enhance the meaning of the current study's findings by contextualising these findings within a review of relevant literature (see Chapter 3).

2.7 ETHICAL CONSIDERATIONS

Ethics involve the consideration of moral obligations that one ought to conform to, especially when the research involves human subjects whose rights need to be protected (Brink *et al.*, 2012:32-34). Ethical considerations refer to the protection of the participants' rights, obtaining informed consent and the institutional review process, known as ethical approval (Klopper, 2008:71). In this study, the researcher complied with the following ethical standards which were grounded within the following fundamental ethical principles.

- **Right to self-determination and justice**

The right to self-determination refers to veracity which refers to the principle of justice, meaning "being fair to participants and not being discriminatory on the grounds of age, sex, class or race". The right to self-determination is the ethical principle of respect for persons because humans are capable of controlling their own destiny, and they should be treated as autonomous agents who have the freedom to conduct their lives as they choose without external controls (Burns & Grove, 2009:187; Moule & Goodman, 2009:57). This right was respected in the way informed consent was obtained.

- **Informed consent and voluntary participation**

In this study, the participants were informed about their right to give consent (self-determination) at their own will and that they would be given time to consider their participation without being influenced by anyone (Burns & Grove, 2009:173; Brink *et al.*, 2012:34). According to Brink *et al.*, (2012:34-35) and Burns and Grove (2009:173), the

consent of participants is accepted legally and professionally only when the participants have been properly informed, and have agreed without any coercion and are deemed competent to give consent. In this study the researcher provided a detailed explanation about the research project and process and the informed consent form to be signed if they decide to participate. The participants' decision to give consent was voluntary, and if they decided to withdraw from the study at any time, they would not be discriminated against in any way, and their decision would not interfere with the study or their practice.

Consideration was given to the potential participants who were. These participants were requested to print their thumbprint or initial that they understood the explanations. A witness had to co-sign with them to confirm that they had made their mark willingly.

- **Right to privacy, confidentiality and anonymity**

According to Burns and Grove (2009:185), privacy encompasses confidentiality and anonymity. Confidentiality means that the participants have a right to expect that any information that they provide will only be used with their consent (Brink et al., 2012:35; Moule & Goodman, 2009:65). In this study, the co-interviewer and the co-coder who had access to the data, were required to sign confidentiality agreements with the researcher (see Annexure H).

During the data collection, the researcher and the interview team used code numbers (unique numbers) instead of the participants' names on the consent forms and on all the data collected on the field notes and audiotapes. This served as a reference to the participants in order to achieve anonymity and to protect the participants' identity.

Collected data will not be available for people not directly involved with this study. The participants were assured that all the information obtained on audiotapes, field notes and transcripts would be secured while the study was still busy and will be kept in a locked cupboard in the office of the director of the focus area at the Potchefstroom campus of the North-West University for a period of five years, following which, all documents containing data will be destroyed. They were also informed that data collected on electronic devices (voice recorder and computer protected by a secure password) would be destroyed after copies had been made on external drives that would be stored with the paper copies.

- **Beneficence and protection from harm**

In this study, the participants were protected from any kind of discomfort throughout the research process (Brink et al., 2012:35-36). Participants were not subjected to any physical harm as the interviews were conducted in a warm and safe environment. In case any interviewee might have experienced emotional stress during an interview, the researcher, as a registered nurse, would have assisted such a person and would have been able to refer any distressed interviewee to a relevant professional person. In such cases the researcher would have accompanied the person to the referral site, but this was never necessary. Every interviewee had the researcher's contact details and could phone the researcher in case they wished to discuss anything after the conclusion of the interview.

2.8 TRUSTWORTHINESS

Qualitative researchers ensure rigour by implementing openness, relevance, epistemological and methodological congruence, scrupulous adherence to a philosophical perspective, thoroughness in collecting data, and consideration of all the data in the analysis process, and the researcher's self-understandings (Burns & Grove, 2009:54).

In this study, trustworthiness was ensured by adhering to the criteria identified by Lincoln and Guba (1985), (cited by Botma *et al.*, 2010:232). The researcher ensured rigor by using the following epistemological standards specified by Lincoln and Guba (1985): truth value, applicability, consistency, and neutrality to ensure that the accuracy and validity of the findings were adhered to. For each of the standards used, the researcher adhered to the specific strategies and criteria which include credibility, transferability, dependability and conformability; in order to ensure rigor in this research (Botma *et al.*, 2010:232; Klopper, 2008:69-70).

- **Truth value / Credibility**

Truth value determines whether the researcher has confidence in the truth of the findings with the participants and the context in which research was undertaken (Botma *et al.*, 2010:233, Brink et al., 2012:97). Therefore, truth value was obtained by using the strategy of credibility.

Moule and Goodman (2009:188-189) indicate that data presented in any qualitative research report has to be credible. Those reading the research report must believe that the data presented is a true representation of the participants' views, experience or beliefs, and have confidence that the interpretations remain faithful to the insiders' views. For the research findings to be credible there should be a detailed description of the setting, all the components of the population and all the steps taken during the study (Polit & Beck, 2001:539).

In this study, credibility was enhanced through peer debriefing. Peer debriefing was used to consult with other impartial colleagues to review and explore various aspects of the enquiry during data collection in order to avoid bias in the research process. An independent research expert co-coded the data analysis. The data collected were documented accurately and verified to give a true reflection of the deliberations. Some of the interviews which were partly conducted in English and Sesotho were analysed directly from Sesotho by Sesotho speakers to protect the scientific integrity, as some of the meaning could get lost if translated from the original language use.

- **Applicability / Transferability**

According to Brink *et al.*, (2012:173), Polit and Beck (2004:435) and Lincoln and Guba (cited by Botma *et al.*, 2010:297), transferability refers to the degree to which data can be generalized to other settings or groups other than the ones studied. The responsibility of the researcher is to provide sufficient descriptive data in the research report to enable readers to evaluate the applicability of the data to other contexts. In this study, the researcher facilitated transferability of findings by providing detailed descriptions of the settings and the context, and by providing verbatim excerpts in the research report so that researchers and other consumers could compare the descriptions with their own contexts.

Literature exploration, interpretation and integration with the results of the individual interviews were done to provide a clear description to ease transferability from one context to another.

- **Consistency / Dependability**

Consistency considers whether the findings will be consistent if the inquiry was replicated with the same participants and in a similar context. The techniques of

increasing dependability include the use of an audit trail and the use of outside reviewers to evaluate the authenticity of the research process and the interpretations of data (Botma *et al.*, 2010:233; Brink *et al.*, 2012:172). In this study, the researcher maintained regular communication with the supervisor who monitored the research process so that any emerging problems could be addressed timeously. Also, the researcher worked with an independent co-coder who independently analysed the data collected during the semi-structured interviews. Thereafter, she had discussions with the researcher to agree on the common themes, and the process was completed by reaching consensus on the common themes that emerged from the data. The researcher was able to compile conclusions based on the data.

- **Neutrality / Conformability**

Botma *et al.*, (2010:233) define conformability as the degree to which the findings are a function solely of the informants and conditions of the research and not of other motives or perspectives, requiring an audit trail to be maintained. According to Brink *et al.*, (2012:173), conformability guarantees that the findings, conclusions and recommendations are supported by data and that there is an internal agreement between the investigator's interpretation and the actual evidence.

The researcher has to refrain from bias during the research process and while describing the results and be as neutral as possible (Botma *et al.*, 2010:233). The researcher used reflexivity to reflect on her role as researcher in order to avoid possible bias by making sure that her own behaviour and preconceptions did not influence the findings of the research in any way. The researcher's role was to act as a research instrument, as a collector and interpreter of the data (Moule & Goodman, 2009:189). The selection of participants for the study depended upon their knowledge and experience (purposive sampling) and were not selected in a biased manner.

The researcher used the strategy of conformability to measure the objectivity of the data. The pretest interview conducted and the verbatim transcriptions and the field notes were evaluated by the study's supervisor (an experienced and published qualitative researcher) before the researcher was allowed to continue with the rest of the interviews. The study's supervisor guided the researcher throughout the research process by auditing and appraising the researcher's findings to establish the trustworthiness of the data. The researcher made use of field notes for verification and to ensure triangulation and to increase trustworthiness of the data and the findings. The

findings were subjected to an audit by the independent co-coder to confirm the trustworthiness of the data (Moule & Goodman, 2009:190). The report of the study has verbatim excerpts from participants depicting major themes, in order to enable the reader to make his/her own interpretations of the data and to compare them with those of the researcher.

2.9 SUMMARY

Chapter 2 described the research design and research methods followed in this study, the measures taken to ensure trustworthiness and ethical accountability. The results of this current study and the related literature are presented in chapter 3.

CHAPTER 3

PRESENTATION AND DISCUSSION OF RESEARCH FINDINGS

3.1 INTRODUCTION

Chapter 2 dealt with a detailed description of the research design and process the researcher followed in this study - the methods used to collect and analyse data that would be trustworthy and comply with the ethical standards of research. This chapter presents the research findings derived from the analysis of the data obtained during the semi-structured interviews conducted with traditional midwives, registered nurses and members of the LUMMHC. The findings will be supported by relevant direct quotations (where appropriate) and will be compared and contrasted with findings reported by other researchers.

The following interview schedules were used in the semi-structured individual interviews used for data collection from the three stakeholder groups. These interview schedules are available in Annexure D and were also presented in chapter 2 of this dissertation.

3.2 PARTICIPANTS' BIOGRAPHIC PROFILES

The biographic data include the respondents' ages, gender, level of education and their years of experience as traditional midwives, or of working with the traditional midwives at the health centres or being a member of the LUMMHC. The biographic data of the participants are illustrated in the tables 3.1-3.3.

Table 3.1 Biographic data of traditional midwives (n=12)

Age	There were two participants in their forties, whilst four of them were in their fifties, and six were in their sixties.
Gender	All participants were females.
Educational level	Nine of the participants completed primary school level whilst three reached high school level.

Trained as village health workers (VHWs)	Five participants were trained as VHWs.
Years of experience working as a traditional midwife	All 12 participants had more than five years' experience of working as traditional midwives.

Most of the participating traditional midwives were older than 40 years of age. They were all experienced as all had at least five years' experience. Only five out of 12 traditional midwives were trained as VHWs some years ago.

Table 3.2 Biographic data of registered nurses (n=9)

Age	Four of the participants were between thirty and forty years of age; four were in their forties, whilst one was in her fifties.
Gender	Most participants were female; only one was a male.
Educational level	All participants had tertiary education and were qualified as registered nurses and midwives. Two had additional qualifications in PHC.
Years of experience working with traditional midwives	Eight participants had more than five years' experience working with traditional midwives and one had four years of such experience.

The age of most of the participating registered nurses ranged from 35 to 54 years of age. All participants had tertiary level education. Most participants had more than five years' experience, with only one participant who had four years' experience of working with traditional midwives.

Table 3.3 Biographic data of Lesotho Universal Medicine Men and Herbalist Council members (n=5)

Age	Two participants were in their fifties, whilst three participants were in their sixties.
Gender	There were four males and one female.
Education level	All participants had primary and high school education, whilst three had tertiary level education
Years of experience of working as members of the LUMMHC	Most of the participants had more than five years' experience, except one who had one year's experience.

All of the participants on the LUMMHC sample were older than 50 years of age and almost all had more than five years' experience of working as council members. Thus these five respondents were experienced in the management issues of the LUMMHC.

3.3 FINDINGS ACCORDING TO THEMES AND CATEGORIES

In this section, consensus was reached about five main themes and 16 categories as presented in table 3.4. The findings of the research will be discussed and supported with relevant quotations from the transcripts of the individual interviews of the three groups of role players (traditional midwives, registered nurses and LUMMHC members), and compared and contrasted with relevant literature findings. In this discussion, the perceptions of the three groups of role players will be integrated and discussed in dialogue with the related literature. The excerpts are referred to with the participant's number from the related group of the transcript on which the extract appears. A total of 21 interviews (12 with traditional midwives, indicated as TMs, and nine with registered nurses, indicated as RNs) were conducted before data saturation was reached. All five members of the LUMMHC, indicated as TCMs, were interviewed. Conclusion statements of each theme are provided before discussing the next theme.

Table 3.4 Summary of themes and categories

THEMES	CATEGORIES
Perceptions of traditional midwifery practice	Positive perceptions
	Negative perceptions
Perceptions of roles of other role players to improve the practice of traditional midwifery	Role of registered nurses
	Role of LUMMHC members
	Role of other role players
Perceived needs to improve the practice of traditional midwives	Knowledge needs
	Physical needs
	Collaboration needs at local level
Perceptions of role players concerning the regulation of traditional midwifery practice	Perceptions of the three stakeholder groups pertaining to the regulation of traditional midwifery practice
Suggestions related to strategies for the regulation of traditional midwifery practice	Collaboration at government level
	Legislation
	Registration, licensing and certification
	Reporting
	Investigating and disciplinary hearings

3.3.1 Perceptions of traditional midwifery practice

The first theme evidenced from the interviews, focuses on the perceptions of traditional midwifery practice with specific focus on the participants' positive and negative perceptions.

3.3.1.1 Positive perceptions

The positive perceptions with their sub-categories are listed in the table 3.5. The positive perceptions are the perceptions raised by the participants from all three stakeholder groups, which reveal the value or recognition traditional midwifery practice has in the community and within the health sector.

Table 3.5 Sub-categories of positive perceptions

Categories	Sub-categories
Positive perceptions	Cultural acceptability
	Marked contributions to the health system
	Rural environment

- **Culturally acceptable**

“Some pregnant women prefer to deliver at home.”

Some of the registered nurses and LUMMHC members mentioned that some pregnant women preferred to deliver their babies at home assisted by traditional midwives. At home no one would be interfering with the pregnant women and they would be able to perform their cultural practices and beliefs in order to protect their children, and also to ease the delivery process. Their perceptions are illustrated by the following quotations:

“There are some women who choose to deliver at home where no one will be interfering with them.” (RN2);

“Some pregnant women prefer to deliver at home.” (TCM1)

“Pregnant women are given herbs (concoctions) with the belief that they [the herbs] will ease delivery.” (RN3)

“Some pregnant women prefer to be assisted by me [traditional midwife] because of poverty, no clothing or food to eat. I have learnt that some opt to deliver at my place to avoid being exposed because they sometimes do not have clothing for their new born.” (TCM1)

Families might feel more comfortable having a woman give birth at home where family members could support her (Prata *et al.*, 2011:89; Olusanya *et al.*, 2011:475). Some women might choose the services of traditional midwives even when clinic and/or hospital services are available and accessible, indicating that the health system must learn from traditional midwives to create more culturally acceptable and respectful ways

to care for women. Traditional midwives are financially more affordable as the study's participants indicated that no payment was expected by the traditional midwives for their services. The family of the delivering woman might offer chickens, sheep or vegetables instead of having to pay a fixed consultation and hospital fees. Also, the traditional midwives provided other essential support services such as helping with household tasks and looking after the woman's other children (Donnay, 2000:95).

Various studies reported that 80% of African people consult traditional midwives to meet their health needs before they visit a clinic or a hospital (Abodunrin *et al.*, 2010:78; Jali, 2009:5; Kaingu *et al.*, 2011:495; Kasilo *et al.*, 2010:7; Kasilo & Trapsida, 2010:25; Kassaye *et al.*, 2006:127; Olusanya *et al.*, 2011:475). Despite the higher survival rates of mothers in childbirth at health facilities, these facilities will always be hard-pressed to compete with traditional midwives' services in terms of comfort, familiarity, the presence of family members, and attention to valued cultural practices (Olusanya *et al.*, 2011:486; Prata *et al.*, 2011:89).

Furthermore, there are various reasons why women prefer to deliver their babies at home. The study of Olusanya *et al.* (2011:486) on infants delivered in maternity homes run by traditional birth attendants in urban Nigeria, reported that some women preferred traditional midwifery homes in order to avoid some interventions implemented in hospitals, rigorous dietary requirements as well as disrespectful and shameful comments from caregivers. Some women could prefer to deliver their babies at home, assisted by traditional midwives, for economic and non-economic reasons including convenience, privacy, cost of hospital delivery and lack of an escort during labour in hospitals/clinics. According to Olusanya *et al.* (2011:487), teenage mothers were more likely to use traditional midwifery homes because of the stigma and embarrassment they were likely to encounter in hospitals (especially as unmarried women), while older women (>35 years) were more likely to choose hospital deliveries because of their obviously high obstetric risk status. Comparatively, in the United States of America (USA), Chmell (2012:143) reported that 20% of mothers delivering in hospital settings reported that they would have preferred traditional midwives and nonhospital deliveries. However, they were concerned because no medical back-up services would be available, if required.

Traditional midwifery seems to remain a challenge globally. Despite arguments that women have a right to choose whether or not to be assisted by a traditional midwife,

obstacles in some societies might compromise this decision, especially in countries where traditional midwifery practices are illegal.

“There are some cultural practices where usually after the birth of a child, there are prepared traditional herbs given to that child, with the purpose of protecting a child against certain things known to them.” (RN3)

Traditional midwifery practice cannot be ignored because traditional midwives are perceived to be part of the cultural and social life of the communities where they live, implying that they are trusted by the community as they speak the same language and understand the tribal culture (Chamberlain, 2013:2; Kaingu *et al.*, 2011:495-499; Murigi & Ford, 2010:2; Olusanya *et al.*, 2011:485-487; Whitaker, 2012:2). African people are spiritual in nature and believe in the existence of ancestors who play an important role in their treatment; in relation to the patient’s family and community (Jali, 2009:8). Therefore, in the African context, traditional midwives are often the first to be consulted because of the considerable influence they have in the community (Donnay, 2000:95; Jali, 2009:8; Kaingu *et al.*, 2011:495). In the African culture, the individual is explained in terms of his/her service to the group (Gumede cited by Jali, 2009:22). Culture plays a major role in the African context.

The findings reported by the Technical Task Force in Nigeria (2012:85) support the current study’s findings as it also indicated that the VHWs provide health care services in remote areas where access to formal health care is difficult and help where there are cultural and other reservations to changing existing behaviours. Cultural practices exert a great influence on women’s decisions to opt for home deliveries conducted by traditional midwives. This is because the traditional midwives and VHWs are members of the community; therefore they are known, accepted and trusted by the community they serve. Therefore, the success of the maternal-child health interventions within a community requires a careful understanding of the local culture and customs surrounding childbirth and the role of key stakeholders, including traditional midwives (Darmstadt *et al.*, 2009:107).

Traditional midwifery services remain inevitable and widespread in rural areas due to the lack of or poor access to established health facilities. For this reason, traditional midwifery practice cannot be ignored (Olusanya *et al.*, 2011:475). Furthermore, in Lesotho, there is growing evidence suggesting that, regardless of their socio-economic

status, many women in urban areas where physical access and financial barriers to facility-based obstetric services are minimal also prefer the services offered by traditional midwives either in their residential homes or in commercial traditional maternity or herbal homes. The women prefer traditional midwives because of cultural reasons.

- **Marked contributions to the health system**

Some of the participants who are traditional midwives and one LUMMHC member expressed their opinions that traditional midwives saved lives of people who lived far from the health facilities.

“Re boloka maphelo a batho ba lulang hole le litsi tsa bophelo.” (“We save lives of people who are far from the health facilities.”) (TM4, TM12)

“Re thusa batho ba hlokang thuso e potlakileng ka nako eo.” (“We assist those with emergencies at the time.”) (TM3)

“There is a contribution we make to the communities because some health centres are very far to reach, and some people could lose their lives while travelling to the health centre.” (TCM5).

Similar findings were observed by Prata *et al.* (2011:82) who reported that in Sub Saharan Africa (SSA), Asia and Pacific, Arab States, Latin America and the Caribbean, each country contains large, underserved rural areas where women traditionally give birth at the home. Therefore, the high rates of poverty, great distances to facilities, and inadequate transportation, remain factors contributing to serious complications which could cause the death of a mother and/or new-born. Therefore services provided by traditional midwives will continue to serve people in many communities (Olusanya *et al.*, 2011:476).

With many deliveries occurring outside of the health centre and an estimated proportion of only 9-15% of deliveries requiring emergency interventions, Olusanya *et al.*, 2011:486) maintain that the important role of traditional midwives for providing convenient, easy-to-reach delivery services should not be overlooked. Kabayambi (2013:1) and Kityo (2013:1), in their studies conducted in Uganda, both found that traditional midwives continued to conduct home deliveries because they were

inexpensive, comfortable and readily available in places without health facilities. Traditional midwives are known within communities, with some having delivered up to four generations of children in one family. That is because traditional midwives were preferred by some rural mothers, whereas up to 80% of pregnant women continued to seek traditional midwives' services (Jali, 2009:5; Kasilo *et al.*, 2010:7; Kasilo & Trapsida, 2010:25; Kityo, 2013:1).

The services of the traditional midwives are not limited to delivery, but include nutritional counselling during pregnancy, advice on family planning and contraceptives, menstrual problems, infant circumcision, as well as special support for unmarried women. In the case of Lesotho, traditional midwives and VHWs are trained to provide women living in rural mountainous villages with access to comprehensive services, including: HIV testing, counselling and treatment; methods of preventing HIV transmission from mother-to-child, and prenatal, delivery and general post-birth health care, immunisations and general reproductive health services. Traditional midwives serve as a link between the clinic and the pregnant women (Partners in Health – Lesotho, 2011:1).

The WHO and Global Health Workforce Alliance Report (2008:5) also indicated that in 2006, the WHO alerted the world to a shortfall of 4.3 million trained health workers globally. The WHO target for Lesotho to meet the Millennium Development Goals standards (since replaced with the Sustainable Development Goals) was 1.73 nurses and midwives per 1 000 persons. However the 2008 ratio was only 0.46 nurses and midwives per 1 000 persons (WHO and Global Health Workforce Alliance, 2008:5). There is also increasing pressure on human and capital resources and shortage of critical skills and expertise due to high attrition of health personnel (Lesotho HSS project, 2012:5; LMOHSW, 2011a:21; LMOHSW, 2014:7). These shortages were found to be a global problem that affects many countries in different ways, but the greatest shortages were seen in the poorest countries. Unless drastic appropriate measures are implemented, the situation is likely to become even worse (WHO & Global Health Workforce Alliance, 2008:5), making the services of traditional midwives even more important.

The Technical Task Force Report (2012:2) revealed evidence that the VHWs have been internationally recognised for their notable success in reducing morbidity and averting mortality among mothers, new-borns and children. Further, it was found by the WHO and Global Health Workforce Alliance (2008:39), that for countries to effectively address

population health needs and tackling a country's high burden of disease, requires policies that focus on health services provided at the community level. Traditional midwives can contribute to these health services at community level. Traditional midwives were officially recognised in 1978 by the Alma-Ata Declaration on PHC as being an important resource for achieving health for all by the year 2000 (Kasilo *et al.*, 2010:7-8; WHO & Global Health Workforce Alliance, 2008:39; WHO, 1978).

Lesotho adopted the PHC approach in 1979 as the focal strategy for attaining health for all by the year 2000 (Lehmann & Sanders, 2007:5; Lesotho Africa Health Workforce Observatory, 2012:22; Lesotho HSS Project, 2012:2; LMOHSW, 2011d:1). Even though the strategy was adopted, challenges obstructed the implementation of the strategy such as the absence of clear policies, the changing health environment, inappropriate management and planning practices, loss of human resources for health and weak co-ordination between the government and its partners. During 2008 there was a thorough revitalisation of PHC and Health Systems Strengthening towards achieving the Millennium Development Goals (MDGs) (LMOHSW, 2011d:1); which led to the development of the CHW programme which incorporated traditional midwives in these training programmes. The aim of the programme was to make health care accessible, affordable and acceptable to individuals and families in the community through their full participation and at a cost that the community and country could afford (LMOHSW, 2011a:26; LMOHSW, 2011d:1-4). The WHO also promoted the legalisation and training of traditional midwives, for them to be integrated into the health system, and the low-income countries were encouraged to develop a traditional midwifery training programme (Darmstadt *et al.*, 2009:593). Currently, based on the WHO guidance, the LMOHSW is no longer recruiting and training new traditional midwives. Where traditional midwives still exist, their function is to refer women to deliver at health centres or hospitals and not to assist with home deliveries anylonger (Lesotho HSS report, 2012:4-5; LMOHSW, 2011d:6)

Contrary to Lesotho, it has been observed that in order for Uganda to deal with traditional midwives' continued practice, it incorporated them into the village health teams (VHTs) which offer advice on basic health care to rural communities on topics ranging from detecting signs of complications or illness among pregnant women and babies, and encouraging women to deliver their babies in health centres. Jali (2009:60) also showed that in South Africa many traditional midwives received training and had

been certificated to function as qualified CHWs who are encouraged to refer patients to a clinic when western medicine is needed. In turn, the clinic reports to the traditional midwives and in some instances refer patients suffering from African diseases (like those individuals possessed with evil spirits - thokolosi) to the traditional midwives. No similar finding has been found in the current study.

The terms, VHW and CHW have been used interchangeably in Lesotho, and the CHW programme is coordinated by the LMOHSW (2012b:2). Despite the existence of outdated policies, there is a need to develop guidelines for the regulation of current traditional midwifery practice in Lesotho.

- **Rural Environment**

“Some areas are in the hard to reach areas where there are no roads, and the vehicles cannot reach such areas.” (RN1) (RN4)

Some of the interviewed registered nurses and the traditional midwives, mentioned that home deliveries were conducted due to limited access to health centres. Some of the areas are very remote making it difficult for the clients to reach the facilities in time due to poor roads and walking long distances along the foothills.

“There would be no transport to deliver a labouring woman to the health centre.” (RN1)

“There is no network in some areas when there is need to call a health centre to report emergencies and request for transportations.” (RN1)

“Some pregnant women travel long distances to the health centre, and some are not able to reach the health facilities in time.” (RN1)

“Ke khothaletsa hore pepiso ea bapepisi metseng e tsoele pele hobane hase mosali e mong le e mong oa mokhachane a khonang ho fihla setsing sa bophelo ka nako. Re boloka maphelo a batho ba lulang hole le litsi tsa bophelo.” (“I recommend that home deliveries conducted by traditional midwives should continue because it is not every pregnant woman who is able to reach the health facility on time. We save lives of people who are far from the health facilities.”) (TM4)(TM10)

“Tsébetso ea bapepisi metseng e bohlokoa hobane re thusa batho ba lulang hole haholo le litsi tsa bophelo.” (“Traditional midwives’ practice is important because we provide services to those people who live in the far to reach areas.”) (TM7)

Similar findings were reported by Murigi and Ford (2010:2) and Whitaker (2012:2) who highlighted that in rural Uganda, despite the banning of traditional midwives, they continued to assist with most home deliveries. This challenge is evident in areas where women do not have access to formal health services. The journey to a health centre can be long and many families are unable to pay for transport costs and/or, in some countries, for the cost of hospital/clinic treatment when they arrive at these facilities. This implies that many women continue to deliver their babies at home, likely to be assisted by traditional midwives (Chamberlain, 2013:1). Other researchers such as Kaingu *et al.* (2011:499) and Prata *et al.* (2011:83), support the findings of the current study as they gave evidence that in SSA, the maternal mortality ratio (MMR) remains high largely as a result of political, socio-economic, cultural and topographical barriers impacting negatively on timely access to emergency obstetric care. Therefore, factors such as poverty, long distances from health facilities, extreme weather, geographic distances, traditional belief systems, weak transportation systems, over-worked staff, and exhaustion of health facilities must be realistically considered. Access to transportation and communication are critical to improve maternal and infant outcomes in many countries (Kabayambi, 2013:2).

The reviewed literature has shown that within the African countries, traditional midwifery cannot be ignored because it continues to exist within communities despite it not being encouraged. This is influenced by culture, social life, beliefs and rural environment which limit access to formal health facilities due to the topography of the country.

Some of the registered nurses and the traditional midwives also argued that they supported home deliveries to a certain extent. This is the case because the traditional midwives provided assistance in remote areas, and the people living in those areas are disadvantaged because of limited access to health facilities. They also felt that something has to be done to assist traditional midwives to do things correctly in order to use them profitably.

“I support home deliveries to a certain point, if only there are trained traditional midwives.” (RN1)

“In the past, the traditional midwives were taught to conduct deliveries, and they offered a good service at that time and saved lives to those women who were not able to reach the facility on time. They attended to emergencies.” (RN4)(RN5)

“The traditional midwives are aware that the environment has to be clean when conducting home deliveries.” (RN1)

“Ke khothaletsa hore pepiso ea bapepisi ba metseng e tsoele pele hobane hase mosali e mong le emong oa mokhachane a khonang ho fihla setsing sa bophelo ka nako.” (“I recommend that deliveries conducted by traditional midwives should continue because it is not every pregnant woman who is able to reach the health facility on time. We save lives of people who are far from the health facilities.”) (TM4)(TM10)

Similar findings were reported by Kabayambi (2013:1) in his study, about “revising the policy on traditional birth attendants,” where that author reported about a traditional midwife who was one of the study participants and was also the chairperson of the traditional midwives. This traditional midwife mentioned that no pregnant woman or child died during her practice. She kept her birthing place hygienically clean, always used new razor blades, gloves and bleach. She always referred primigravids (women delivering their first babies) to the hospital. The findings from Chamberlain (2013:4), in his study about examining the role of traditional birth attendants in the continuum of care in Sierra Leone, support the findings of the current study. That author found that traditional midwives wanted to continue doing their work for the benefit of their communities, for their own respect, and for respect from the community members. Jali (2009:7) emphasised that European Western medicine has not been able to reach those that need it most because of its rising costs, and the complex and expensive nature of medical technology. Western medicine has become expensive because of its increasing reliance on sophisticated technology for both diagnostic and therapeutic purposes (Jali, 2009:7).

3.3.1.2 Negative perceptions

Negative perceptions refer to participants' revealed negative impacts of traditional midwifery practice on the community and on the health system. A study by Kabayambi (2013:1) revealed cases where women had been mismanaged by traditional midwives and died or ended up with serious morbidities such as fistulae. The sub-categories of the negative perceptions are listed in table 3.6.

Table 3.6 Sub-categories of negative perceptions

Categories	Sub-categories
Negative perceptions	Not encouraged traditional midwifery practices
	Risky practices

- **Traditional midwifery practices not encouraged**

Some of the members of the three stakeholder groups mentioned that even though the traditional midwives' practice had not been encouraged and no support was provided for the practice in Lesotho, there were traditional midwives who continued to conduct home deliveries despite that.

“Ha rea lumelloa ho pepisa ho hang. Ntle leha ho hlokahala thuso e potlakileng, joale eba ha ho bobebe ho mokhachane ho fihla setsing sa bophelo.” (“We are no more allowed to conduct deliveries at all. Unless in cases where there are emergencies, and it is not easy for a woman to reach the facility.”) (TM3)

“Re thusa batho ba hlokang thuso e potlakileng ka nako eo. O thusa mosali oa mokhachane ele ho boloka bophelo ba hae le ba ngoana, feela o qetella o le tsietsing ka etsa joalo.” (“We assist those with emergencies at the time. You innocently assist the pregnant woman to save the life of the woman and the child, but you end up being in trouble for that.”) (TM3)

“Home deliveries have not stopped because we still have cases of those home deliveries being reported to the health centre.” (RN1)(RN2)(RN4)(RN5)

“The pregnant women come to us secretly because they are told not to come to us anymore.” (TCM2)

“There are some women who do not come to the health centre at all, and we still meet with those that delivered at home during the outreaches.” (RN1)(RN2)(RN8)

Similar findings were reported by Kityo (2013:1), in his study as he asserted that Ugandan traditional midwives are not allowed to conduct home deliveries as they are expected to refer all pregnant women to formal health facilities. The traditional midwives in Uganda had been officially banned since 2010, but still continued to work, mostly in rural areas, despite the legal ban on their services. Lesotho has not officially banned traditional midwives, but they have not been encouraged from conducting home deliveries. Nevertheless some traditional midwives continued to conduct deliveries in Lesotho.

In Nigeria a similar situation was reported where 60-80% of all deliveries occurred outside modern health facilities with a MMR of 700-800/100 000 live births (Abodunrin *et al.*, 2010:78). In rural Nepal, similar findings were reported by Thatte *et al.* (2009:601), where the MMR remains 740 per 100 000 live births. In Sierra Leone a traditional midwife, named Hannah, was fined for assisting a pregnant woman during a home delivery as this practice had been banned. This woman did not have money for transport to deliver her baby at the district hospital (Whitaker, 2012:1).

- **Risky practices**

Most interviewed registered nurses and one traditional midwife felt that traditional midwifery practices were risky to the traditional midwives themselves, to the pregnant women and to the new-born babies. The registered nurses are aware that the traditional midwifery practices have not been encouraged, but they still continue practising without authorisation.

“I do not encourage them to conduct deliveries because those are risky practices.”(RN1)(RN2)

“We do not need them anymore.” (RN4)(RN7)(RN8)

“Traditional midwives put the lives of the mother and the child in danger because they conduct deliveries without any knowledge of the complications that may occur.” (RN6)

“If we encourage traditional midwives to conduct deliveries, we would be putting their lives at risk of being infected with HIV/AIDS etc.”(RN1)(RN2) “They expose themselves to HIV and hepatitis because they use bare hands when conducting deliveries.” (RN1)(RN4)(RN8)

“Re ile ra bolelloa hore re emise ho pepisa, re ipeha kotsing ea ho fumana tsóaetso hobane ha re itsireletse. Hape, ha re khone ho hlokomela mokhachane kamora pepo.” (“We were told to stop conducting deliveries as we are exposing ourselves to infections because we do not protect ourselves. Also, we are not able to take care of the woman after delivery.”) (TM1)

Similar findings were reported in a study conducted by Murigi and Ford (2010:1), in Uganda where they identified mismanagement by a traditional midwife who assisted a pregnant woman (Salome) to deliver at home and exposed her to infections. *“The traditional midwife had performed an episiotomy on Salome, but she was still unable to get the baby out. With Salome unconscious, the traditional midwife took drastic action by using the kitchen knife, she performed a caesarean section and in the process cut through Salome’s uterus and sliced open her bladder.”* Salome went through this traumatic situation because she did not have money to travel to the district hospital which was 54km away in the rural areas of Uganda (Murigi & Ford, 2010:1).

Whitaker (2011:1) reported that the experts who participated in that study believed that the women were putting themselves at serious risk by relying on traditional midwives. This was the case because the traditional midwives could not handle obstetric complications such as haemorrhage, eclampsia and obstructed labour - conditions accounting for three-quarters of maternal deaths. It was further emphasised that untrained traditional midwives often used unsafe delivery procedures. Kaingu *et al.* (2011:499) also reported that traditional midwives rarely used gloves during deliveries, implying a serious risk of HIV transmission from woman to traditional midwife and vice versa and/or from client to client in situations where the traditional midwife attended to more than one client simultaneously. In support of the above evidence, Murigi and Ford

(2010:2) asserted that the traditional midwives' lack of knowledge and use of traditional practices could be risky for their clients (women and babies).

Jali (2009:47) argued that even though the relationship between the traditional midwives and PHC providers was strengthened in some countries; in other countries each traditional midwife works in isolation within his/her own sphere. The findings of the current study showed that traditional midwifery practices have been continuing despite the fact that they have not been encouraged, exposing the pregnant women and their babies, together with the traditional midwives, to infections due to risky practices performed by some traditional midwives.

3.3.1.3 Conclusion statements regarding the perceptions of traditional midwifery practice

This first theme relates to the perceptions of the stakeholder groups towards the traditional midwifery practice. The main observations made were:

- Some pregnant women prefer to deliver their babies at home assisted by traditional midwives because they observe their cultural values and traditions.
- Traditional midwives make a valuable contribution to communities and within the health sector, as they save lives in rural communities in the hard-to-reach areas.
- Traditional midwifery practices continued even though they had not been encouraged in Lesotho.
- Traditional midwifery practice might expose the pregnant woman, the new-born child and the traditional midwives to infections, therefore these risky practices need to be regulated.

3.3.2 Perceptions of roles of other role players to improve the practice of traditional midwives

The second theme addresses participants' perceptions of roles of other role players involved in the practice of traditional midwives to influence improvement of traditional midwifery practices. These role players included registered nurses, the LUMMHC members, the LMOHSW, the chief and the counsellors, and the traditional healers. The sub-categories regarding the perceptions of the roles of other role players are listed in table 3.7.

Table 3.7 Sub-categories of the role of other role players to improve the practice of traditional midwives

Category	Sub-categories
Role of registered nurses	Registered nurses' own perceptions
	According to other role players
Role of LUMMHC	According to LUMMHC members
Role of other role players	Lesotho Ministry of Health and Social Welfare (LMOHSW)
	Traditional healers
	Chiefs and counsellors

3.3.2.1 Role of registered nurses

The role of the registered nurse in this context refers to the functions and the responsibilities the registered nurses have towards improving traditional midwifery practice.

- **Registered nurses' own perceptions**

Some registered nurses mentioned that while working at health centres, they supervised traditional midwives ensuring that safe care was provided to the community. This was done through traditional midwives' identification and assessment of pregnant women, and through referrals and accompaniment of pregnant women to the health centre. Safety is facilitated as they provide equipment for traditional midwives to protect themselves.

The perceptions of the participants were cited as:

"The nurses have to supervise these people."

"The public health nurse should take control of the traditional midwives. The nurses also have to supervise these people." (RN2)

“The traditional midwives accompany and follow up on the pregnant women to the health centre, hence assisting registered nurses to monitor pregnant women in time in order to avoid complications.” (RN3)(RN4)(RN5)

“They ensure that those that are not well are sent to the health centres where they are attended by the registered nurses and get their medications as prescribed, e.g. TB suspects and HIV positive clients.” (RN5)(RN7)

“We give them gloves so that they would assist every client who would need assistance while at home to prevent exposure to any risks of infections. The traditional midwives care for the bed ridden patients at home.” (RN1)

“In the past, the traditional midwives were taught by us how to conduct deliveries, and they offered a good service at that time and saved lives to those pregnant women who were not able to reach the facility on time. They attended to emergencies.”(RN4)(RN5)(RN1)

Similar findings have been observed by Jali (2009:60) and the LMOHSW (2012b:4), they both reported that supervision by registered nurses starts with training of the traditional midwives, then followed by certification to function as qualified CHWs. Registered nurses at the health centres supervised and trained the CHWs (including some of the traditional midwives) either at the health centres or in the villages. They conducted monthly meetings with the community leaders and the CHWs for reporting, sharing problems and being informed about new events (LMOHSW, 2011d:10). The traditional midwives received training on various activities including maternal and child health and family planning, referrals, follow-up of clients and record keeping (LMOHSW, 2011b:13; LMOHSW, 2011d:6-10). Even though the registered nurses supervised the traditional midwives, the LMOHSW (2011a:19) reported that supportive supervision for the community system was inadequate.

It was further found by Jali (2009:60) in his South African study that traditional practitioners, including the traditional midwives, reported to the clinic, and in turn, the clinic provided feedback to the traditional practitioners and in some instances referred those patients suffering from African diseases to the traditional practitioners. The role of the registered nurse is specified by the LMOHSW (2011d:6) as assessing, monitoring and assisting pregnant women to deliver when they had been referred and

accompanied by the traditional midwife an/or the CHW. The traditional midwives claimed that they assisted pregnant women during emergencies and those who were unable to reach the health centres in time; and then referred them to the health centre to get the necessary treatment.

The Lesotho HSS Project (2012:2) and the LMOHSW (2011d:4) reports confirmed the participants' inputs, as they stated that the community level services were delivered through community owned village health posts where they existed, and the activities at this level were provided through traditional midwives and CHWs referring clients to the health centres to be attended by registered nurses.

The role of registered nurses mainly focusses on supervision and monitoring of pregnant women who attended clinics at the health centre and training of the traditional midwives. According to Abodunrin *et al.* (2010:79), without effective and efficient supervision and monitoring, the training of traditional midwives would not have the desired impact in reducing maternal mortality rates.

- **According to other role players**

The role of a registered nurse is described here by other role players, namely the traditional midwives and the LUMMHC members because traditional midwifery practice links them together, for the benefit of the clients who need care.

Some of the traditional midwives and the LUMMHC members expressed that the role of the registered nurse was to supervise the traditional midwives' practice by ensuring that they provided safe care to the clients; and protected them from any dangers or risky practices. According to the International Council of Nurses (ICN, 2012:5), it is a nurse's responsibility to take appropriate action to safeguard individuals, families and communities when their health is endangered by a co-worker or any other person. The nurse should take appropriate action to support and guide co-workers to advance ethical conduct.

“Ke sebelisa litsebo tsa khale. Empa kamora ho pepisa, ke tlaleha setsing sa bophelo, ebe ke khothaletsa mosali oa mokhachane ho ea setsing sa bophelo.”
(“I use the old practices I used to do in the past. But after delivering, I report to the health centre and encourage the pregnant woman to go to the health centre for further assistance.”) (TM1)

“I work together with the health centre nurses, and I encourage my clients to attend the clinics in order to get the modern medications.” (TCM1)

“We usually report to the health facility, the chief and the counsellors when anything goes wrong.” (TM4) (TCM1)

“The nurses taught us in the past, and we used to work with them. Things changed lately when we were told to stop conducting deliveries.” (TCM1)(RN1)

According to the study conducted by Lehman and Sander (2007:20) in Lesotho, supervision of the CHWs and traditional midwives was the responsibility of the registered nurses working at the health centre. The LMOHSW (2011d:10) report also supported these findings of the current study as it stated that there were existing mechanisms which include monthly meetings, regular refresher training sessions and getting support from the chiefs, VHCs and community councils. Despite the existence of these mechanisms, they were weak, especially supervision and follow-up of patients at community level. It was further highlighted that the greatest need for supervision existed in the most remote areas where health services were overstretched and ill-equipped. It was further described by Lehman and Sanders (2007:20) that supervision is a vehicle through which the quality of health care services can be assured. However, supervision as function, typically receives neither the human nor the financial support required to successfully conduct and sustain the necessary supervisory activities.

Some of the traditional midwives and LUMMHC members felt that they had a role of working together with the registered nurses for the benefit of the clients because there were clients who preferred to consult traditional midwives.

“Ho bohlokoa hore bapepisi ba metseng ba sebetse mmoho le litsi tsa bophelo hobane hona le batho ba bontsáng ho se khotsofale ka tsébetso ea litsi tseo.” (It is important that the traditional midwives work together with the health centres because there are those people who complain about the services provided at the health centres. (TM7)

“Basali ba bakhachane batla ho rona ka lekunutu ele hobane ba joetsitsoe hore ba se ke ba hlotse ba tla ho rona hohang.” (The pregnant women come to us secretly because they have been told not to come to us anymore.) (TCM2)

“Re hloka ho sebetsa mmoho le lekala la bophelo hobane ke rona ba khotlaetsang basali ba bakhachane ho ea litsing.” (“We need to work together with the Ministry of Health because we are the ones who encourage the pregnant women to go to the health centres.”) (TCM2)(TCM4)

Jali (2009:47) emphasised that there was a need to create opportunities to improve communication and co-operation between traditional midwifery practice and Western medicine to enable patients to benefit from both practitioners to meet their health-related needs. The challenge was to ensure that the knowledge and skills of the traditional midwives were enhanced enabling them to render safe services to their clients.

The CHWs were assigned the responsibility by some governments to perform home visits, check on environmental sanitation and the provision of the water supply, providing first aid and treating simple and common ailments, providing health education, give nutrition advice and maintain such surveillance, provide maternal and child and family planning services, manage the control of communicable diseases, monitor community development activities, refer patients as necessary, keep records, and collect data on vital events (Evidence Review Team, 2012:10; Lehman & Sanders, 2007:8; Lesotho HSS report, 2012:11; LMOHSW, 2011d:8; Technical Task Force Report, 2012:20-85; WHO & Global Health Workforce Alliance, 2008:40). The findings of the current study revealed that even though some traditional midwives had been integrated in the CHW programme, not everybody was part of the programme.

3.3.2.2 The role of the Lesotho Universal Medicine Men and Herbalist Council

The role of the LUMMHC is to regulate all traditional health practices within the country.

Some of the council members mentioned that the council’s role is protecting the public through the regulation of traditional healers’ practices, by ensuring that safe care is provided to the public by stating:

“If traditional midwives are involved in any kind of malpractice, we have a responsibility to take action as per our 1978 Constitution which generally states that we need to protect and safeguard the care provided by the traditional healers.” (TCM5)

“The Council protects our practice.” (TCM1) “It oversees traditional practices within our region.” (TCM1)

The WHO report (2001:20) about the “legal status of traditional medicine and complementary medicine,” and the LUMMHC Act (1978:62-63) state that the LUMMHC’s role is to register and keep a record of the traditional medicine practitioners, and to ensure that every registrant has a valid license to practise. It also has a responsibility to promote and control the activities of the traditional medicine practitioners, to provide facilities for the improvement of their skills; and to bring together all traditional medicine practitioners into one associated group. The Act further states that it is an offence to form or encourage the formation of any other association of traditional medicine practitioners. The LUMMHC Act (1978:62-63) does not address the practice of traditional midwifery practice.

“We are not responsible for any malpractices done by the traditional midwives, and do not have any legal mechanisms in place.” (TCM2)

“No action is taken by the council when the traditional midwifery malpractices do occur.” (TCM2)

Donnay (2000:94), in her study also found that there is a need to establish a national regulatory framework to enable traditional midwives to practise in a variety of settings. This finding supports the current study findings indicating a need to establish a regulatory framework because the LUMMHC has not incorporated traditional midwifery practice into its regulatory framework.

It is common practice that traditional midwives are integrated into the CHWs, but there is no special regulation which addresses the regulation of traditional midwives. Lehman and Sanders (2007:6) found that the control measures existing in various countries included that the traditional midwives were integrated into the CHW programme; and that the CHWs were used primarily to render basic, mostly curative health services, within homes and communities and to assist health professionals with their tasks.

3.3.2.3 Role of other role players

The role of the other role players is discussed with the notion of how it links with traditional midwifery practice.

- **Ministry of Health and Social Welfare**

Some of the members of the three stakeholder groups mentioned that the role of the LMOHSW focuses on supporting all stakeholders who provide health services to the community at all levels.

All of the participants further emphasised a need for the Ministry of Health and the Council to work together. The perceptions of the participants were cited as:

“The Ministry of Health has to provide support to the services provided by the traditional midwives.”(TCM2)

“Traditional midwives need to be provided with resources by the Ministry of Health in order to protect them during provision of care.” (TCM1)(TCM4)

“The Council should work with the Ministry of Health in order to strengthen the health services.” (RN1)

“Bapepisi metseng le lekala la bophelo ba hloka ho sebetsa mmoho le ho fihlela litumellano ka tsébetso e sa lokeloang ho etsoa.” (“The traditional midwives and the Ministry of Health need to work together and reach an agreement on the practices that should not be done.”) (TM2)(TM1)

“Re hloka ho sebetsa mmoho le lekala la bophelo hobane ke rona ba khothaletsang basali ba bakhachane ho ea litsing tsa bophelo.” (“We need to work together with the Ministry of Health because we are the ones who encourage the pregnant women to go to the health centres.”) (TCM2)(TCM5)

“Ho bohlokoa hore re sebetse mmoho le lekala la bophelo, ele hore re arolelane thuto ea rona, molemong oa tlhokomelo ea sechaba, e sireletsehileng kahohle.” (“It is important that we work together with the Ministry of Health so that we share and learn from each in order to care for the community, and to prevent exposure to infections from all sides.”) (TM1)

In support of the findings of the current study, the LMOHSW (2012b:15) stated that the role of the LMOHSW pertaining to the traditional midwives and the CHW programme is to provide overall guidance, oversight, regulation and control of the health sector. This should be done through the formulation of policies and strategic plans, development

and enforcement of health care standards, development and management of national health programmes, ensuring quality of services through supervision and quality management and monitoring as well as the evaluation of the health services and health status of Lesotho. The LMOHSW has to mobilise resources for health services, plan and implement human resource development, plan and develop health infrastructure. The maintenance of quality care is the responsibility of the LMOHSW (LMOHSW, 2012b:15).

The participants expressed concern that the LMOHSW does not work with them, nor recognise, the traditional midwives.

“We do not work with the Ministry of Health, and there is no coordination between the two. There are conflicts between the two.” (TCM2)

“No action is taken by the Council because we are not recognised by the Ministry of Health.” (TCM2)

Similar findings were portrayed by Jali (2009:46), in the South African policy guidelines, which strongly recommended that the role of the traditional midwives together with the traditional healers should be recognised, and integrated into the national health care system. The Lesotho HSS Project (2012:2) report also noted that traditional healers were not formally included in the health service structure, even though they were integral to the health system.

- **Traditional healers**

One of the council members and one registered nurse mentioned that they worked with the traditional healers through the provision of traditional herbs and consultations in cases where complications might arise, therefore with the support of the traditional healers, the traditional midwives' practice could be improved.

“The traditional midwives work with the traditional healers and are accountable to the traditional healers. We have identified individuals in all the districts, and we have committees that work with them and share issues of their practices.” (TCM2)

“There is the health centre committee within which there is a traditional healer representing the traditional healers.” (RN1)

The traditional healers are respected members of the community and are more attuned to prevention and fortification, which is how they link with the traditional midwives. Even though the findings show that traditional midwives worked with traditional healers, the traditional midwives did not fall within the jurisdiction of the LUMMHC. Comparatively, in South Africa, Jali (2009:6) found that there was pluralistic health care system where both Western medicine and traditional African medicine operated in parallel streams but in isolation of each other without collaboration.

- **Chiefs and counsellors**

Some of the registered nurses and traditional midwives mentioned that when any kind of malpractices occurred within the village, they reported these to the chief, the counsellors and the health centre.

“It is the role of the chief and the counsellors to oversee all activities within his area of jurisdiction. When the chief gets reports, he takes action and reports the matter to the higher authorities.” (RN7)(RN8)

*“Morena, macounselara le basebeletsi ba bophelo metseng ba sebetsa mmoho le setsi sa bophelo, ele ho bona hore tsébetso ea bapepisi metseng eea laoloa, ka ho etsa hore mokhachane e mong le e emong o pepela setsing sa bophelo.”
 (“The chief, the counsellor and community health workers have to work with the health centre to ensure that traditional midwifery practices are controlled by ensuring that every pregnant woman delivers at the facility.”) (TM2)*

“When there have been any home deliveries conducted, the chief together with the community health workers have to take action against the traditional midwives immediately because the women and the children’s lives are in danger at the time.” (RN2)(TM4)

*“We need to work with the chief, counsellors and the community as a whole to make the community aware of the importance of delivering at health facilities.”
(RN4)(RN6)*

There seems to be variations in the participants’ feelings regarding traditional midwifery practice because some participants expressed stronger feelings indicating that traditional midwifery was forbidden and should be reported to the chief, counsellors and

the health centres, and then such culprits should be punished. However, some seemed more lenient as they mentioned that guidance and support were required to address the challenges. The study findings also showed that actions taken by the chief when home deliveries had been conducted was inconsistent. Some chiefs did take action against traditional midwives who continued to conduct deliveries, whilst others seemed to be lenient. A participant mentioned that one chief was also a traditional midwife. The finding of this study could be unique because no similar discovery had been reported in other studies of a similar nature that could be accessed by the researcher.

The responsibility of the chief is to assist the health centre with the selection of CHWs. The CHW network involves relevant local health leaders in service delivery, including traditional healers, traditional midwives, rural caregivers and the nurses working in the rural area (Lehman & Sanders, 2007:18; Towle & Lende, 2008:225). There should be prominent community collaboration in village development work.

The researcher also found that the members of the three stakeholder groups were aware that traditional midwifery practice should be controlled; although it was reportedly controlled at the community level, there was no regulatory body to which traditional midwives belonged.

“Morena o na le boikarabello baho nka mahato ha bohlasoa tsébetsong ea bapepisi metseng bo etsahetse motseng, le ho bona hore mosali eo o eea setsing sa bophelo moo.” (“It is the chief’s responsibility to take action when the malpractice has occurred within the village, and to ensure that the woman goes to the health facility after delivery.”) (TM3)

“Tsébetso e bohlasoa e tlalehoa ho morena le macounselara, le setsi sa bophelo, ele hore taba eo e fuputsoe, ele hore lihato tsa molao li nkuoe.” (“The mismanagement has to be reported to the chief, the counsellors and the health centre so that the issue is investigated so that legal action is taken. (TM9)(TM11)

The study findings showed that the registered nurses, the LMOHSW, the chiefs, counsellors and the traditional healers have significant roles unique to their settings, which could contribute to the improvement of traditional midwifery practice in Lesotho.

3.3.2.4 Conclusion statements regarding the perceptions of the roles of other role players to improve the practice of traditional midwives

This second theme relates to perceptions of roles of other role players to improve the practice of traditional midwives. Such role players include the registered nurses, the LUMMHC members, and other role players including the LMOHSW, the traditional healers, the chief and the counsellors.

The main observations made were:

- The registered nurses provided a supervisory role to the traditional midwives.
- Supportive action is taken by the registered nurses, the chiefs and the counsellors when the deliveries conducted by the traditional midwives were reported to the health centre.
- The role of a registered nurse was to ensure that the traditional midwives provide safe care through training and supervision.
- The role of the LUMMHC was to regulate the traditional healers. The LUMMHC Act of 1978 does not make any provisions to address traditional midwifery practice and the legal mechanisms, for addressing misconducts are non-existing. Therefore, there is a need to incorporate traditional midwifery practice in this 1978 Act.
- The role of the MOH was to provide support through providing resources and training, and by recognising the traditional midwives by integrating them into the health system.

3.3.3 Perceived needs to improve the practice of traditional midwives

The third theme evidenced from the individual interviews focused on the needs of the traditional midwives for improved traditional midwifery practice to promote client safety.

3.3.3.1 Knowledge needs

The participants felt there was a need for traditional midwives to gain knowledge and acquire skills in order to use them profitably, to harness all the available resources. The training would enable the traditional midwives to acquire the necessary skills to be able to provide safe care as they had done in the past.

Table 3.8 Sub-categories of knowledge needs

Categories	Sub-categories
Knowledge needs	Training
	Guidelines / manual

- **Training**

The majority of the members of the three stakeholder groups verbalised that the traditional midwives needed to be trained like in the past in order to gain knowledge and skills so that they could provide safe care. Their perceptions were cited as:

“If the resources were available and the traditional midwives were properly trained, I do not think there would be a problem because they would have acquired proper knowledge and skills.” (RN1)

“Re hloka ho rutoa joaloka pele, ebille re ne re sebetsa le bona.” (We need to be educated like before and continue working with the nurses at the health centres.) (TM1)

“They should be trained and invited to the workshops because the traditional midwives are still conducting deliveries anonymously.” (RN2)(RN5)

“Ha re ne re ka lumelloa ho pepisa le hore ebe re fuoa lisebelisoa tse kang li glove.” (If we could be allowed to conduct deliveries and provided with equipment like gloves.) (TM5)(TM9)

“Baoki ba ne ba re ruta khale, ebille re ne re sebetsa le bona.” (The nurses taught us in the past, and we used to work with them.) (TM1)

“Ke khothaletsa hore bapepisi ba metseng ba koetlisoe molemong oa ho thusa ka ho pepisa metseng, le hore ba rutoe ka likotsi tse ka bang teng ka nako eo ea pepiso molemong oa ho fana ka thuso e sireletsehileng.” (I recommend that traditional midwives should be trained to assist in conducting deliveries,

and made aware of the complications that may occur in order to provide safe care.” (TM7)(TM9)

“Traditional midwives should be trained to gain more knowledge and skills to be able to provide safe care.” (TCM2)(TCM4)

The lack of standardisation of traditional midwives' knowledge, attitudes, and practices about maternal and new-born health services, remained a challenge to improve maternal outcomes (Thatte *et al.*, 2009:606). It was further mentioned by Darmstadt *et al.* (2009:593) and Whitaker (2012:2) that the WHO stated that until there are sufficient midwives, the best policy is to train traditional midwives to perform simple outreach work so that they could monitor low-risk pregnancies while referring more complicated cases to clinics.

The Lesotho HSS Project (2012:4) indicates that from 1979 to the early 1990s, training materials, manuals and guidelines for community-based volunteers were developed and utilised. The programme included the traditional midwives selected by the community and the majority of the traditional midwives were selected for training and played a dual role as a traditional midwife and a VHW. The WHO guidelines advised the LMOHSW that it should no longer recruit and train new traditional midwives in Lesotho (LMOHSW, 2011d:6). Following the Alma Ata Declaration in 1978, the WHO actively promoted the legalisation and training of traditional midwives. Historically, the WHO first supported training of the traditional midwives, then decided that births must only be conducted by skilled attendants (health professionals), then realised there are not enough skilled attendants and backtracked to again support the training of traditional midwives under certain circumstances (Kasilo *et al.*, 2010:8-9; Lesotho HSS project, 2012:4; WHO, 2013:43). The current study's findings emphasised the need for Lesotho to go back to the training of the traditional midwives because there are still not enough professional skilled attendants to assist women during childbirth. The shortage is particularly critical in the rural areas of the country.

Abodunrin *et al.* (2010:78) in their Nigerian study and Kaingu *et al.* (2011:499) in their Kenyan study, identified aspects that needed to be included in the training which such as the dangers of the transmission HIV/AIDS and other sexually transmitted diseases (STDs) during pregnancy, the use of herbs during pregnancy, and the importance of timeous referrals to reduce maternal and child mortality rates. The LMOHSW (2011d:9)

and Partners in Health – Lesotho (2011:1) reports supported the training of traditional midwives as CHWs providing comprehensive services to women living in rural mountain villages, including HIV testing, counselling, and treatment, delivery assistance, immunisations and general reproductive health services.

Jali (2009:48) recommended that there should be training in traditional medicine for all health professionals. It was further recommended by Jali (2009:48) and Olusanya *et al.* (2011:485) that the curricula for training those health professionals should include basic elements of PHC and public health, and should also ensure that both traditional medicine and Western medicine understand and appreciate the complementary nature of health care (Jali, 2009:48; Olusanya *et al.*, 2011:485).

Partners in Health – Lesotho (2011:1) and Partners in Health – Rwanda (2011:10) also confirmed that traditional midwives after being trained, should locate and accompany the pregnant women throughout their pregnancy and birth to ensure that they have full access to the clinic's comprehensive services in order to avoid complications. The perceptions of clients were not addressed. Traditional midwives need regular training, in-service training, regular monitoring and supportive supervision in order to promptly refer high risk and complicated pregnancies and deliveries (Abodunrin *et al.*, 2010:83). It is therefore pertinent that appropriate education and training programmes on the proper use of traditional midwives should be provided.

- **Guidelines / manual**

Some of the registered nurses expressed the need for Lesotho to develop a training manual and guidelines which will provide guidance to the traditional midwives in order to ensure the provision of safe care.

“There should be guidelines which guide the traditional midwives on which deliveries they can perform, and which ones they cannot perform at all, but need to refer and accompany the woman to the health centres.” (RN1)

“There should be a manual which offers guidance and outlines the traditional midwives scope on what they are expected to do and not to do.” (RN1)

In addition to training, traditional midwives need a reference manual that could also be used as the training manual. Darmstadt *et al.* (2009:593), in their study about “60

million non-facility births: who can deliver in community settings to reduce intrapartum-related deaths” also reported that in 2000, 85% of low-income countries had traditional midwives’ training programmes and the WHO policy recommended guidelines to integrate traditional midwives into the health system of the country. Lesotho has a training manual and guidelines for CHWs developed by the WHO, and had approved the then training of traditional midwives, even though it is outdated (Lesotho HSS project, 2012:2-6; LMOHSW, 2011b:11; LMOHSW, 2011c; LMOHSW, 2011d:9).

3.3.3.2 Physical needs

The physical needs refer to the resources utilised by traditional midwives during their practice.

Table 3.9 Sub-categories of physical needs

Categories	Sub-categories
Physical needs	Resources: gloves, kits
	Transport and communication

A majority of the members of the three stakeholder groups mentioned that the traditional midwives needed to be provided with resources to be able to prevent exposure to infections and maintain safety while performing their practices.

- **Resources: gloves, kits**

The participants’ perceptions were cited as:

“Re ka fua li kit le thepa e kang liatlana (gloves) le mahare hore re sireletse ‘má le ngoana.” (“We can be given kits with the necessary equipment like gloves, blades so that we protect the mother and the child’s lives.”) (TM6)

“They come and request for gloves, and we do give them because they still do home-based care.” (RN1)

“Re fumana lisebelisoa tse kang li glove mane setsing sa bophelo bakeng sa ho itsireletsa khahlanong le tsóaetso.” (“We do get the resources like gloves from the health centre to protect us against infection.”) (TM1)

“Ha re ne re ka lumelloa ho pepisa, ebe re fuoa lisebelisoa tse kang li glove. Re hloka ho koetlisoa ele ho ntlafatsa litsebo tsa rona tsa ho pepisa.” (“If we could be allowed to conduct deliveries and be provided with equipment like gloves. We need to be trained so that we improve our skills.”) (TM5)(TM9)

“Traditional midwives need to be provided with resources by the Ministry of Health in order to protect themselves during provision of care.” (TCM1)(TCM4)

Similar findings to those of the current study were observed in the study conducted by Thatte *et al.* (2009:604), which was about traditional birth attendants in rural Nepal. Those authors found that the traditional midwives were aware of the importance of clean deliveries and tried to deliver in a clean room or in a separate room, if available, when they had proper equipment to use. The studies of Thatte *et al.* (2009:604) and Darmstadt *et al.* (2009:S107) also indicated that providing traditional midwives with clean birth and immediate new born care kits improved home-based childbirth outcomes.

- **Transport and communication**

Some registered nurses mentioned that even though home deliveries were not encouraged, the authorities had to consider the disadvantaged people living in very remote areas where access to health facilities was restricted because of serious transport challenges.

“There are some areas in hard-to-reach areas where there are no roads, and the vehicles cannot reach such areas.” (RN1)(RN4)

“Some pregnant women travel long distances to the health centre, and some are not able to reach the health facility in time.” (RN1)

“There would be no transport to deliver a labouring woman to the health centre.” (RN1)

“There is no network in some areas when there is need to call a health centre to report the emergencies and request for transportation.” (RN1)

Access to transportation and communication are critical to improve maternal and infant outcomes (Kabayambi, 2013:2; Prata *et al.*, 2011:82). Major contributing factors to maternal deaths are delays in recognising danger signs, deciding to seek care, reaching care, and receiving care at health facilities. Therefore, these are health system components that must be addressed by the governments.

In order for the countries to address the infrastructure challenges related to maternal mortality, innovative tools and technology are important potential means for increasing the effectiveness of interventions (Darmstadt *et al.*, 2009:107). Developing and adapting tools and technologies for use in more peripheral health settings might help to bring pregnant women in the community closer to facility care, such as the use of cellular phones or resourceful transport vehicles like bicycle stretchers. This approach might also improve childbirth care at home. Prata *et al.* (2011:88) emphasised that to achieve high coverage in rural communities depends on available workforce, terrain, infrastructure, and political will.

The findings of the current study expressed by some of the registered nurses supported Darmstadt *et al.* (2009:107) findings, as both studies suggested a need for ambulances, taxis or bikes that could transport pregnant women to health centres. The participants' perceptions are illustrated as follows:

“To those that did not show up at the shelter and are still far from the health centre, I think if there are ambulances and taxis that could assist in transporting those women to the health centre if there are any emergencies that do occur within the village.” (RN2)

Some of the registered nurses recommended that the villagers would hire a vehicle to immediately take a woman in labour to the health facility. An official arrangement should be established for the use of the ambulances or the local taxis which could be contracted to assist with transportation in emergencies.

“All health facilities have been renovated to enable nurses to conduct deliveries at health centres. The problem would only be when there is no water at the health centre; that would then make it difficult for nurses to conduct deliveries.

In case where transport is a problem, the villagers would hire a vehicle to immediately take the woman to the facility.” (RN4)

On the other hand, the registered nurses recommended that overall health care services needed to improve, and traditional midwives required sufficient supplies.

“Even if we train them, education will not help because there are no resources.” (RN4)

“There are shortages of resources; therefore I do not encourage home deliveries because of shortages ...” (RN1)

Similar findings were reported by Murigi and Ford (2010:3) in their study conducted in Uganda, they asserted that unless measures are taken to improve healthcare services and access to these services, banning traditional midwives would be meaningless. Resources are not traditional midwives’ only problem, they also need to address issues of transport, ensuring all health centres have the correct equipment and educating communities about all aspects of essential obstetric care.

Traditional midwives’ access to physical resources would enhance their ability to provide safe care to the traditional midwife, the pregnant woman and her child, and timeous referrals, when necessary.

3.3.3.3 Collaboration needs at local level

Collaboration addresses the linkages or the working relationship between the relevant stakeholder groups in order to reach the common goal based on improving the practice of traditional midwives, and it will be discussed according to the sub-categories listed in table 3.10.

Table 3.10 Sub categories of collaboration needs at local level

Categories	Sub-categories
Collaboration needs on local level	Collaboration between registered nurses and traditional midwives
	Referrals

	Shelters (waiting areas)
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- **Collaboration between registered nurses and traditional midwives**

Some of the members of the three stakeholder groups mentioned that linkages/ collaborations between the traditional midwives and the registered nurses were weak because traditional midwifery practice had been discouraged. Therefore traditional midwives who continued to conduct home deliveries performed their practice secretly because they did not want to be known. That is because they could face serious legal consequences.

“...Women come to us secretly”

In Chapter 1 of this dissertation, it has been indicated that the WHO guidelines indicated that the LMOHSW should no longer recruit and train new traditional midwives in Lesotho. Where traditional midwives exist, their function is to refer women to deliver at health centres or hospitals (LMOHSW, 2011d:6). Similar findings were observed by Jali (2009:40) that many developing countries would be unable to attain the goal for health unless collaboration with traditional practitioners through PHC is adopted. The WHO also encouraged member states to facilitate collaboration on integration and strengthening of traditional practitioners and western medicine (Kasilo *et al.*, 2010:12; WHO, 2013:25).

The participants' perceptions are cited below:

“There is the health centre committee within which there is a traditional healer representing the traditional healers.”(RN1)

“There is stronger network between the chiefs, counsellors, community health workers and the health centres. The networks are helpful in keeping a watchful eye on the community, thus ensuring that disciplinary action will be taken if any kinds of malpractices do occur in the community.” (RN5)(RN5)

“Basali ba bakhachane ba tla ho rona ka lekunutu hobane ba joetsuoe hore ba se ke ba hlola bat la ho rona.” (“The pregnant women come to us secretly because they are told not to come to us anymore.”) (TCM2)

“There are community health workers in the villages that advise the community on health issues and notify the nurse at the health centre if there are any emergencies.” (RN2)RN9)

“The public health nurse should take control of the traditional midwives. The registered nurses also have to supervise these people. The chief and the community can also help in controlling these people.” (RN2)

“Hona le kopano ea morena le macounsela ha hona le litlaleho tse hlahang ho sechaba, ha hona le se etsahalang.” (“There is involvement of the chief and the counsellors as they get all the reports of everything that is happening within their community.”) (TM4)

According to Jali (2009:47) in some countries, the relationship between traditional midwives and PHC providers was being strengthened. This had been observed in Lesotho where some of the traditional midwives and the CHWs worked together and served as a link between the communities (where they lived and practised) and the formal health centres (Chamberlain, 2013:7; Partners in Health – Lesotho, 2011:1). But, in many other countries, including Lesotho, each category still continues to work in isolation within its own sphere, even though there has been co-operation between traditional midwives and Western medicine (Jali, 2009:47).

- **Referrals**

The registered nurses mentioned a significant reduction in home deliveries since traditional midwifery practice has been discouraged, as the traditional midwives work with the CHWs by assisting with screening of the clients, referring and accompanying them to the health centre. The pregnant women are encouraged to stay at the waiting mothers’ shelters to be monitored by registered nurses until they are due to deliver. The waiting mothers’ shelters are buildings made near the clinics or hospitals to accommodate pregnant women who are staying far from the facilities in order to be monitored in time, and to avoid travelling long distances and delivering at home.

“Pregnant women are encouraged to stay at the shelters for the last two weeks of their gestation period.” (RN4)

“The community health workers identify pregnant women and provide health education to them on how they should take care of themselves; accompany and follow up on them to the health centre.” (RN3)(RN4)(RN5)

“Those that stay far away from health facilities should be booked to stay at the shelters to ensure that they deliver at the health centre and are properly monitored.” (RN2)(RN8)

In Uganda, it has been observed that many of the traditional midwives are doing a good job with home deliveries as the pregnant women and children have never been lost in their hands. This was because the traditional midwives always referred pregnant women delivering their first babies to the health facilities, and never assisted them with deliveries (Kabayambi, 2013:1; Murigi & Ford, 2010:2). Nevertheless, there were reported cases where pregnant women were mismanaged by traditional midwives and died or ended up with serious morbidities such as fistulae. However, in some countries like Uganda, traditional midwives were incorporated into the VHTs which were responsible for providing advice on basic healthcare to rural communities on topics ranging from detecting signs of complications or illness among pregnant women and babies to reduce maternal and perinatal mortality and morbidity rates (Kityo, 2013:1; Murigi & Ford, 2010:2).

Kabayambi (2013:2) emphasised that traditional midwives could become instrumental when they are formally integrated in the health system to assist during normal deliveries, and to refer pregnant women to health facilities or skilled health workers when there are complications. Their role should be to promote change in societal attitudes towards birth, and provide friendly care arising from their natural, maternal and compassionate instincts. This would reduce the cases that have to go through the rather threatening environment of “over-medicalisation”, economisation and politicisation of this natural event.

Some of the registered nurses recommended that during the training of traditional midwives, timely referrals must be emphasised to avoid late referrals.

“The traditional midwives do not refer the women to the health centre immediately, so I consider it to be a malpractice.” (RN2)

“Some women come to the health centre after two days, and you will find that the woman is HIV positive, they don’t monitor anything nor do follow ups.”
(RN1)(RN3)

Abodunrin *et al.* (2010:78-80), in their report, mentioned that the factors associated with delayed or poor referral practices by traditional midwives included the attitude that they could handle cases that they were supposed to refer immediately. There have also been reports that some traditional midwives felt referral of their clients was not important as they claimed they could manage complications in pregnancy. The participants believed that improving working relations and promoting co-ordinated care during referrals would assist in ensuring that pregnant women get monitored properly by appropriate personnel with the required knowledge and skills.

- **Shelters (waiting areas)**

The registered nurses indicated that pregnant women are encouraged to stay at shelters built near clinics or hospitals in order to avoid travelling long distances, and delivering at home where they are assisted by the traditional midwives.

“Since 2014, there has been a significant reduction of the reported malpractices, even though I would not give a rough estimate. They were reduced since the shelters were built.”(RN3)(RN3)

“Those that stay far away from health facilities should be booked to stay at the shelters to ensure that they deliver at the health centre and are properly monitored.”(RN2)(RN8)

“Pregnant women are encouraged to stay at the shelters for the last two weeks of their gestational period.” (RN4)

Similar findings have been reported by Partners in Health – Lesotho (2011:2) and Partners in Health – Rwanda (2011:10) on reducing maternal mortality rates in the remote mountains of Lesotho, and the report compiled by Towle and Lende (2008:223) on community approaches for preventing mother-to-child HIV transmission: perspectives from rural Lesotho. Both studies reported that shelters were constructed near health facilities in Lesotho in order to enable more women to deliver their babies at health centres. Rough terrain separating the remote villages from health centres could

make the journey virtually impossible for a woman with labour complications, so these waiting shelters should enable women to make the journey before labour begins. Hospitals view these residences as a better way for staff to deliver comprehensive VCT and ART, as many Basotho women arrive at the health facilities late in the course of labour, making the procurement of necessary HIV testing, counselling and drugs difficult.

Some of the registered nurses and one traditional midwife argued that even though pregnant women who stay far away from health centres are encouraged to stay at the waiting areas, not all pregnant women would be able to do so. The environment might be uncomfortable, they might be unable to leave other children behind, and the shelters' food might be unpleasant. Therefore it might remain necessary to have trained traditional midwives in remote areas who could handle emergencies.

“Ke nahana hore ho bohlokoa ho bapetisi metseng hore ba fuae tumello ea hore ba tsoele pele ka ho peipisa. Leha ele hore bakhachane ba khotlaetsoa ho lula setsing sa bophelo, hase mokhachane e mong le emong a lulang setsing moo.” (“I think it is necessary for the traditional midwives to be given authority to continue conducting deliveries, even though pregnant women are encouraged to stay at the shelter, it is not everybody who goes to the shelters.”)
(TM3)

“All health facilities have been renovated to enable nurses to conduct deliveries at health centres. The problem would only be when there is no water at the health centre; that would then make it difficult for nurses to conduct deliveries. In case where transport is a problem, the villagers would hire a vehicle to immediately take the woman to the facility.” (RN4)

“The pregnant women are encouraged to stay at shelters for the last two weeks of their gestational period because some of them stay far away from the facilities, and travel long distances. I think the food they are provided with has to be improved because they often complain about the food they eat, and this therefore contributes to their refusal to stay at the shelters.” (RN4)

Despite all the developments made to encourage pregnant women to stay at shelters, it was found that it is challenging for pregnant women in the rural areas, to leave their

homes for two weeks to stay at the waiting areas. It is not a viable option for many women in Lesotho, who are expected to care for children, work in the fields, and maintain their home in their village, especially as many men migrate for work (Partners in Health – Lesotho, 2011:2; Partners in Health – Rwanda, 2011:10; Towle & Lende, 2008:223).

“Even though there are waiting mothers’ shelters made for the pregnant women to be nearer to the health facilities, some still come at the last stage of labour because they say they have other children to take care of at home, as the husband and the grandmother would not be staying with them at the time.”
(RN2)(RN3)

Strengthening collaboration between traditional midwives and registered nurses is one of the strategies that would promote safe health care at grass roots level where there is limited access to and availability of health centres.

3.3.3.4 Conclusion statements regarding the perceived needs to improve the practice of traditional midwives

This third theme addressed the perceptions of the relevant stakeholder groups towards the perceived needs to improve the practice of traditional midwives.

The main strategies include:

- There is a need to train traditional midwives to acquire knowledge and skills in order to provide safe care.
- There should be training manuals/guidelines to guide the practice of traditional midwives.
- There is a need to provide traditional midwives with resources like birth and newborn kits and gloves in order to be able to protect themselves, the pregnant woman and her baby against exposure to infection.
- There is a need for traditional midwives to refer pregnant women timeously in order to avoid serious complications which may result due to referral delays. Referrals can be effective because of the waiting shelters that had been built at hospitals/clinics throughout Lesotho.

- There is a need to use ambulances, local taxis or bikes to attend to emergencies as some of the areas have poor roads and some women might have to travel long distances to reach a clinic or a hospital.
- There is a need to establish linkages between traditional midwives and the MOH in order to ensure that there is strong collaboration between traditional midwifery practice and Western medicine. This collaboration will benefit the community as a whole as those in disadvantaged areas will receive timely care.

3.3.4 Perceptions of role players regarding the regulation of traditional midwifery practice

The fourth theme addressed the perceptions of the role players towards the regulation of traditional midwifery practice. The perceptions of the registered nurses' and traditional midwives' groups have been consolidated, but the perceptions of the LUMMHC members will be addressed separately as the regulatory body seemed to have linkages and a particular interest in traditional midwives.

3.3.4.1 Perceptions of the three groups of role players regarding the need for the regulation of traditional midwives' practice

Regulation is defined by Morrison (2010:9) as the statutory control which ensures that safe and competent care is provided by practitioners who are accountable for their own practice. For the best patient outcomes, governments should ensure that any legislative development or review supports achievement of the regulatory objectives. For regulations to exist, the agreed-upon standards have to be set, competent practitioners have to be registered, the specified titles should only be used by those who are registered, and sanctions such as removing names from the register should be applied to anyone who fails to meet the set standards (ICN, 2007:6). The Lesotho Nursing Council (Lesotho Nurses & Midwives Act, 1998:106) regulates registered nurses and midwives in Lesotho, and has similar regulatory systems in place. Registered nurses are the health practitioners supervising the traditional midwives, and the findings of the current study indicated that they supervised unregulated personnel.

A majority of registered nurse participants in the current study expressed concerns because traditional midwives were conducting home deliveries although traditional midwifery' practice was not encouraged in Lesotho. Some traditional midwives' practice

was not safe as they were exposing pregnant women and their newborn babies to infections. The registered nurses were concerned that no legal action was taken against such culprits, and they had not heard of any council regulating traditional midwives' practice, implying that the traditional midwives were not accountable for their acts and omissions. According to the LMOHSW's policies, the registered nurses knew that malpractices had to be reported to the chief, the counsellors and the DHMT, but this proved to be challenging in some areas as no action seemed to be taken in some areas. In some instances, the chief and counsellors intervened by cautioning a culprit.

The perceptions of the three stakeholders groups were cited as:

"Home deliveries have not stopped because we still have cases of those home deliveries being reported to the health centre." (RN4)(RN5)

"I have not seen or heard about any kind of legal action taken against a person who has been reported with any kind of malpractice; that is why they still continue to conduct home deliveries." (RN1)(RN3)

"Malpractices are reported but no legal action is taken."(RN9)

"There are women who do not come to the health centre at all, and we still meet with those that delivered at home during the outreaches." (RN1)(RN8)

"Some pregnant mothers come to the health centre after two days, and you will find that the woman is HIV positive; they do not monitor anything nor do follow ups." (RN1)(RN3)

"The woman will avoid answering questions because they know that if they continue delivering at home, the traditional midwives who assisted them will be sued." (RN1)

Similar findings were reported by Jali (2009:58) indicating that in South Africa no single statutory body regulates traditional midwifery practice. Murigi and Ford (2010:2) maintained that the decision, made by various countries, to ban traditional midwives is not a solution as governments acknowledged their value in the recent past. Rather governments should take steps to regulate traditional midwifery practice, give traditional midwives uniforms and offer them training.

Based on the above findings, the members of the three stakeholder groups mentioned that there is a need for traditional midwifery practice to be regulated because currently the practice is not regulated as traditional midwives do not belong to any regulatory body. There are no regulatory mechanisms (such as registration, licensing, and certification) in place; hence there is no control of the practice.

“Lingaka tsa setso li lokeloa ho fua matla a ho laola bapetsi metseng, molemong oa sechaba.” (“The Traditional Healers’ Council should be authorised to regulate the traditional midwifery practice for the benefit of the community.”) (TM3)

“Rona bapetsi ba metseng, re lokeloa hore re tsejoe, re ngolisoe ke lekhlotla la lingaka tsa setso.” (“We the traditional midwives, have to be known and registered with the Council.”) (TM6)

“Ha lekhlotla la lingaka tsa setso le ne le ka fua boikarabello ba ho ngolisa le ho fana ka tumello ho bapetsi ba lokelang ho sebetsa, le ho khalema ba fummanoang ka bohlasoa.” (“If the Traditional Healers’ Council would be given responsibility to exercise its mandate to register and authorise traditional midwives to practise, and discipline those that are found with evidence of malpractices.”) (TM12)

“Develop or strengthen the law that regulates the traditional midwives in order to enforce safe practice by encouraging women to deliver at health facilities in order to reduce high maternal mortality.” (RN3)(RN7) “The law should outline all the requirements to be followed in cases where there is limited access and no network; and also state clearly that no one is allowed to conduct deliveries.” (RN7)(RN9)

“There should be a scope which outlines what the traditional midwives are expected to do and not to do.” (RN1) “There should be establishment of the Council for traditional healers including traditional midwives, which should regulate them, and should make rules and regulations for them.” (RN1)

“There is need for us to have a protocol which will guide us on what should be done to report incidences of home deliveries.” (RN8)

“The Council needs to register traditional midwives so that our traditional practices are recognised and we get regulated because there are no mechanisms in place.” (TCM3)(TCM4)

“We need to incorporate the traditional midwives into our Council so that we regulate them. This will be for the benefit of the public health and safety.” (TCM5)

Similar findings have been reported by Jali (2009:44) in her study, which indicated that many countries are developing national policies and regulatory guidelines which define the roles of traditional practitioners in the national health care system. The increased use of traditional practitioners has also made it imperative that there should be policies regarding the licensing of the practice of traditional practitioners. The WHO (cited by Jali, 2009:44) also stated that in the year 2000, only 25% of 191 member states in Africa had policies on traditional medicine. It further stated that a national policy is urgently needed particularly in developing countries where the majority of people depend on traditional medicine for their health care needs. The integration of traditional midwifery into the national health care system could enable the two systems to work effectively together for the benefit of the consumers of health care.

In order for the African countries to strengthen their regulation, there is a need to develop policies that will:

- provide a sound basis for defining the role of traditional practitioners in the national health care system
- ensure that the necessary regulatory and legal mechanisms are developed for the promotion and maintenance of good practice
- promote access to health care that is equitable
- ensure the authenticity, safety and efficacy of any therapy that is being used and
- address issues such as education and training, licensing, research and allocation of financial and other resources and indicate the model of integration to be used (Jali, 2009:45) .

Kasilo and Trapsida (2010:28) showed evidence that the lack of regulation in many countries meant there were many “false” practitioners which could have fatal consequences for their clients.

All members of the three stakeholder groups mentioned that traditional midwives were not regulated by any regulatory body. Their perceptions were cited as:

“I have not heard of any law regulating the traditional midwives. I once experienced two cases of home deliveries which had complications and were reported, but nothing was done.” (RN9)

“Ha ke tsebe hore hona le lekhotla le joalo, ebile ha ke tsebe hore le sebetsa joang.” (“I do not know that there is that kind of the Council and I do not know how it works.”)(TM1)(TM9)

“Ha ke so utloe ka lekhotla le laolang bapepisi metseng.” (“I have not heard of the Council that regulates us.”) (TM2) (TM12)

“Ha ke so utloe ha lekhotla la lingaka tsa setso le nka mahato khahlanong le tsébetso ea rona ha mathata a le teng.” (“I have not heard of the Council taking action when there has been a problem.”) (TM3)(TM4)

“Ha hona taolo holima tsébetso ea bapepisi metseng.” (“There is no control over the traditional midwifery practice.”) (TM5)

The findings of the current study are similar to the study conducted by Jali (2009:4), where she observed that it has been difficult to establish a single statutory council licensing and regulating traditional healers' practices because of the number of potential members. The findings of the current study indicated that even though there was the LUMMHC Act (1978:62-63), which registers and licenses traditional healers, not all traditional healers were registered and licensed; and with particular focus to the traditional midwives, no provision was made for their registration and regulation in terms of this Act, even though they were considered to be part of the traditional healers.

Some of the registered nurses were concerned that the authorities who were expected to take action when the malpractices occur within their jurisdictions were reluctant to take action and even a chief reportedly conducted home deliveries. The registered nurses indicated that the issue became complex when the chief herself conducted home deliveries in the village. This implied that the traditional midwife who was also a chief should have reported any malpractice that occurred to herself.

“I remember one incidence where the chief conducts home deliveries herself, and you wonder how we can take action against a person in authority.” (RN8)

“It is the role of the chief and the counsellors to oversee all activities within his area of jurisdiction.” (RN8)

“Malpractices are reported but no legal action is taken.” (RN9) “Some of the incidences are not reported because the chief or the community takes sides because of their relations.” (RN9)

“We do not know where to report the incidences of home deliveries when they occur.” (RN8)

This could therefore be considered to indicate a conflict of interest because the chief is in a powerful relationship with the authorities and with the community members. No similar finding has been reported by other studies of a similar nature. The findings have revealed that the control measures currently employed within the communities rely solely on the chief, the counsellors and the health centres.

3.3.4.2 Conclusion statements regarding the perceptions of role players regarding the regulation of traditional midwives’ practice

This fourth theme narrates the perceptions of the role players regarding the regulation of traditional midwifery practice. These role players are referred to as the traditional midwives, registered nurses and the members of the Council.

The main strategies in this regard include:

- The traditional midwives were aware they are not regulated; therefore they felt that there was a need to be regulated.
- No members of any of the three stakeholder groups had heard of any law regulating traditional midwives. Therefore, they felt that there was a need for the traditional midwives to be regulated to ensure that legal action could be instituted against those with reported malpractices.
- The members of the LUMMHC were willing that the LUMMHC Act be revised in order to incorporate traditional midwives.

3.3.5 Suggestions related to strategies for the regulation of traditional midwifery

The fifth theme addresses the suggestions raised by the participants on the strategies that could be used to strengthen regulation of traditional midwifery practice.

3.3.5.1 Collaboration at government level

Collaboration at government level relates to the linkages of health service delivery between traditional midwifery practice and the government, implying the LMOHSW. The sub-categories of the collaboration at government level are listed in table 3.11.

Table 3.11 Sub-categories on collaboration on government level

Categories	Sub-categories
Collaboration on government level	Ministry of Health and the LUMMHC
	Involvement of traditional midwives in the LUMMHC

- **Ministry of Health and the Lesotho Universal Medicine Men and Herbalist Council**

The majority of the members of the three stakeholder groups mentioned a need for the LUMMHC to strengthen linkages with the LMOHSW in order to establish clear working relations which will benefit the health of the community.

“Bapepisi metseng ba lokela ho hlokomeloa ke ‘muso ho latela mosebetsi oa bona.” (“The traditional midwives should be given more recognition by the government.”) (RN5)(TM6)(TCM12)

“The Traditional Healers’ Council should work with the Ministry of Health in order to strengthen the health services.”(RN1)

“It is important we get recognition from the Ministry of Health.”(TCM1)(TCM5)

“There is no coordination between the two.”(TCM2)

“If the Ministry of Health would assist with training of the traditional midwives to ensure that they provide safe care.”(TCM5)

“We need to work together with the registered nurses working at the health centres.”(TCM4) (TM10)

Findings similar to those of the study were reported by Jali (2009:6) who maintained that no policy ensured that collaboration and partnership between traditional medicine and European Western medicine existed in the provision of health care in South Africa. It was further mentioned that in South Africa, the traditional and biomedical health care systems operated side by side. African people utilised them simultaneously with the latter enjoying official recognition while, traditional medicine including traditional midwifery, had been frowned upon, marginalised and operated as an informal sector of knowledge. Therefore, Jali (2009:21-25) emphasised that there must be collaboration and partnership between traditional medicine and Western medicine if traditional medicine, including traditional midwifery, is to contribute to human and social development. Improved communication between the two health care sectors is required to ensure effective referrals of patients/clients between the two systems.

Some of the LUMMHC members said that traditional midwives make a valuable contribution to the health system as they care for and assist people who are not able to get to the health facilities in their areas, but their efforts are not recognised by the LMOHSW.

“The Ministry of Health does not appreciate our efforts.”(TCM2)

“The Ministry does not care about the traditional health practices, yet there is a contribution we make.”(TCM2)

Traditional midwives can play a significant role in the provision of PHC services if they are given the recognition they deserve as legitimate caregivers (Jali, 2009:42).

- **Involvement of traditional midwives in the Lesotho Universal Medicine Men and Herbalist Council**

The majority of the members of the three stakeholder groups mentioned that there was a need to incorporate the practice of traditional midwives within the LUMMHC because this council must officially take responsibility of regulating the traditional midwives as

their practice is related to that of the traditional healers. There must also be a traditional midwife representative in the council.

“We need to incorporate the traditional midwives into our Council so that we regulate them. This will be for the benefit of the public health and safety.”
(TCM5)

“The Constitution should be revised to ensure that it addresses regulation of traditional midwifery practices, and registers such practices to enable control and to protect the traditional midwives in case where problems do occur.”
(TCM3)(TCM5)

“We need to have the legal document and be knowledgeable about what is expected of the traditional midwives.” (TCM1)

“Traditional midwives should be part of the traditional Council that will regulate and monitor their practice to ensure that proper action is taken at all times.”(RN2)(RN7)(TM10)

“Lekhotla la setso le lokela ho shebana le taolo ea rona bapetsi metseng, ele ho bona hore re fan aka bosebeletsi bo sireletsehileng ho sechaba le ho rona.”
(*“The Lesotho Universal Medicine Men and Herbalist Council have to oversee and regulate our practice to ensure that our practice is safe to the client and us.”*) (TM1)

“The Council can establish the committee under the umbrella of the Traditional Council. The committee will work with the traditional midwives and oversee the services that are provided by them to the community. The committee will coordinate the services to strengthen linkages between the health centres and the traditional midwives in the villages to promote good relations.”(TCM2)

Jali (2009:58) reported that it has been difficult to establish a single statutory council in South Africa. Pretorius (cited by Jali, 2009:58) also highlighted that the licensing of traditional practitioners in South Africa poses many challenges. There is no single statutory body that regulates their practice, and, even though traditional medicine is poorly regulated, the majority of South Africans continue to use traditional medicine.

In order to address these challenges, Kasilo and Trapsida (2010:25) advised that non-regulation of the traditional and herbal medicines poses a health risk to the population. Therefore, the council has a responsibility to incorporate the traditional midwives because such practices are traditional in nature, and the LUMMHC's objective is to bring together all traditional healers and herbalists into one associated group. Furthermore, membership of the LUMMHC should be open to every traditional healer and herbalist who pays a subscription fee as determined by the constitution of the council and whom the council recommends for membership (LUMMHC Act, 1978:63-64). Therefore, the Act provides for council to make recommendations to accommodate other members who can be regulated by such a council. Other reports have also shown that 21 African countries have developed legal frameworks for traditional practice in order to enhance the safety and quality of services provided to patients (Kasilo *et al.*, 2010:9). The findings therefore show that Lesotho still has an opportunity to revise the existing LUMMHC Act of 1978, in order to regulate traditional midwives' practice.

3.3.5.2 Legislation

The members of the three stakeholder groups agreed that traditional midwives were not regulated by the LUMMHC; and based on that, they verbalised a need for the development of a legal framework clearly outlining the minimum standards of practice.

"We need to have the legal document and be knowledgeable about what is expected of us." (TCM1) (TCM5)

"Melao le melaoana e tlameha ho etsoa ele ho tataisa lekhlotla hore le kenye tsébetsong mekhoa ea ho khalema ho hona le moo bohlasoa bo etsahetseng teng." ("The laws and regulations have to be developed to guide Council to enforce discipline when the mismanagement of the traditional midwifery practice has occurred.") (TM6)(TM7)

"Molao oa lekhlotla o lokeloa ho ntlafatsoa ele hore ho kenyeletsoe taolo ea tsébetso ea bapepisi metseng, le ho ngolisoa hoa bona, ele hore ba laoloe, le ho sireletsa sechaba tsébetsong e mpe ea bapepisi metseng." ("The Constitution of the Council should be revised to ensure that it addresses regulation of traditional midwifery practices, and registers such practices to

enable control and to protect the traditional midwives in case where problems do occur.”) (TCM2)(TCM3)

It has been stated in the LMOHSW (2011d:12) report, that the main piece of legislation guiding the health sector, namely the “Public Health Order of 1970”, is very old and inadequate for addressing the current health reforms, hence the need for revision, and to address the new trends. Also, the policy on VHWs’ activities is weak. Additionally, the WHO (2013:30) has also shown the trend that the national and regional policies and regulations have been established to promote the safe use of traditional practices, even though it still remains a key responsibility of the member states to protect the health of their populations by ensuring the safety of traditional practices and managing its described risks more effectively. Furthermore, the WHO (2013:43) indicated that its strategy is to support member states in promoting the safe and effective use of traditional medicine through regulation, research and integration of traditional practices into the health system. It will also provide support to member states in developing the policies, regulations and guidelines that address those forms of traditional medicine which meet the health needs and preferences of the people.

Chmell (2012:140), in her study observed that some developed countries also struggle to regulate home births as they also did not have laws directly addressing the regulation of home births. Regulations that exists in relation to home births, only indirectly affect these births because the regulation addresses the licensing and regulatory standards for different types of midwives, rather the actual practice of home births and the practice of traditional midwives. Chmell (2012:143) further emphasised that it is important that midwifery and the home birth option should gain the legal recognition needed to make home birth a safe and meaningful option for women.

The member states were further advised by the WHO that they should create standards of practice, establish regulatory frameworks for traditional practices, provide supervision of practitioners including training, accreditation and remuneration, and determine how a service should be delivered within an existing health system (Kasilo & Trapsida, 2010:27; WHO, 2013:51); support the development of a code of conduct to bolster ethical practice, in partnership with all relevant stakeholders; establish provisions for the education, qualification, and accreditation or licensing of traditional practices based on the needs and risk assessments; establish formal channels of communication to facilitate education including continuing education and accreditation, licensing and

registration of practitioners. In an effort to regulate, promote, develop and standardise the practice of African traditional medicine, Kasilo *et al.* (2010:9) as well as Kasilo and Trapsida (2010:25) revealed that 21 countries had developed legal frameworks for traditional medicine practice; while 18 have national codes of ethics for traditional practitioners to enhance the safety, efficacy and quality of services provided to patients.

The Canada Health Professions Act (2008:3-4) and the State of Minnesota (2014:2-3) both made provisions for defining traditional midwifery services, and clearly outlined the scope of practice of traditional midwives, including restricted activities and unauthorised services of traditional midwives. The practice standards and the regulations clearly indicate that a licensed traditional midwife must comply with all applicable state and municipal requirements regarding public health. Morrison (2010:13) also made provision in the ICN Toolkit on the types of regulation which includes the restrictive approaches which describe and impose limitations on aspects of practice. The permissive approaches which describe functions that are less prescriptive and do not define boundaries around the scope of practice. These standards enable the public to be protected. It further shows that for regulation to be effective, the educational and practice standards and competencies, as well as an associated code of practice should be specified (ICN, 2007:17).

The LUMMHC Act (1978:62-63) confirmed that there has been an oversight in the provisions of this Act, to incorporate traditional midwives' practice. The WHO (2001:20) report on legal status of traditional medicine in Africa, commented on the regulatory situation of African countries, from among which reference was made to the LUMMHC Act of 1978 which had not addressed regulation of traditional midwives.

3.3.5.3 Registration, licensing and certification

Registration is defined as where a person satisfies the conditions of admission to a part of the register or roll (Lesotho Nurses and Midwives Act, 1998:113). Licensing is the authorisation to practise after the regulator has assessed the individual and is satisfied that the individual is fit to practice, and has acquired the necessary competencies and qualifications (ICN, 2007:18). Most of the LUMMHC members indicated that traditional midwives should be registered, licensed and certified in order to gain recognition and belong to a regulatory body to which they will be accountable for their acts and omissions.

“Ho bohlokoa hore lekhlotla la setso le re ngolise re le bapepisi metseng, ele ho thusa hore tsébetso ea rona e shejoe ka leihlo le leng lesele, le ho bona hore taolo e teng tsébetso ea rona.” (“The Council needs to register traditional midwives so that the traditional practices are recognised and we get regulated because there are no mechanisms in place.”) (TCM1)(TCM3)(TCM4)

“Molao o hloka ho ntlafatsoa ele hore o kenyeletse taolo ea mosebetsi oa rona bapepisi metseng, hape re ngolisoe le hore taolo e be bobebe, le hore sechaba se sireletsehe moo bothata bo bang teng.” (“The Constitution should be revised to ensure that it addresses regulation of traditional midwifery practices, and registers such practices to enable control and to protect the traditional midwives in case where problems do occur.”) (TCM1)(TCM2)(TCM3)(TCM5)

“Bapepisi ba metseng ha ba ngolisoe ebile ha ba fuoe litokomane tsa lekhlotla.” (“The traditional midwives are not issued with the certificates and registered with the Council.”) (TCM1)(TCM2)(TCM5)

“Bapepisi metseng ha ba laoloe ke lekhlotla la setso, empa le laola ebile le ngolisa lingaka tsa meetlo, le ho ba fa tumello ea tsébetso.” (“The traditional midwives are not regulated by the Council; instead the traditional healers are registered and issued with the licenses. They also have identification document which they use in their practice.”)(TCM3)(TCM4)(TC5M)

Jali (2009:48) mentioned that ideally all health care providers must be trained, qualified and licensed to practise. The Australia National Nursing and Nursing Education Taskforce (2006:10) indicated that a necessary criterion for practising as a nurse or midwife is registration according to legislation of each state or territory. Therefore, traditional midwives need to have a criterion of registration in Lesotho.

Kassaye *et al.* (2006:131), in their Ethiopian study mentioned that a process has been initiated to establish guidelines for licensing, and for establishing minimum standards, for traditional practice and practitioners. Jali (2009:60) also asserted that in the Kwazulu Natal Province of South Africa, many traditional midwives received training and were certified to function as qualified CHWs who were encouraged to bring patients to the hospital when Western medicine was needed. In turn, the clinic reported to the CHWs

and in some instances referred patients suffering from African diseases to the traditional practitioners.

According to the Canada Health Professions Act, (2008:6) and the State of Minnesota, (2014:6), registration, licensure, certification and re-licensure requirements should be specified. These should include the procedures (including specific penalties) taken against a licensed traditional midwife whose license has been revoked by the board because he/she has been prohibited from practising. If all countries would develop similar legal frameworks, traditional midwives would be able to know how to comply with the minimum standards of practice at all times. This initiative could help to reduce maternal mortalities and promote safe care to all pregnant women in remote areas.

3.3.5.4 Reporting

Reporting relates to reporting to the authorities and the regulating bodies about the occurrences of malpractices performed by the traditional midwives so that legal action can be taken against those culprits (Canada Health Professions Act, 2008:6; State of Minnesota, 2014:5-6).

Some of the registered nurses and the traditional midwives mentioned that there were reporting procedures between the community and the health centre.

“Batho ba fumanoang ba tlaleuoe ka tsébetso e bohlasoa ea bapepisi metseng ba tlalehoa ho morena le macounselara, le setsing sa bophelo, ele hore mehato ea molao e nkuoe.” (“The people with such malpractices are reported to the chief and counsellors, and also the health centre for legal action to be taken.”)
(TM2)(TM7)(TM3)

“Family members and community health workers have been informed to report to the health centre immediately.”(RN1)

“The maternal deaths were reported by the community health workers and the chief to the health centre, and then the registered nurse would report immediately to the DHMT and to the Ministry of Health.”(RN5)

Even though the reporting procedures were in place, the participants argued that no action was taken by some authorities, and strict control measures should ensure that order is maintained.

“We do not know where to report the incidences of malpractices when they occur.” (RN8)

“Malpractices are reported but no legal action is taken.” (RN9)

“Some of the incidences are not reported because the chief or the community take sides because of their relations.” (RN9)

In the State of Minnesota (2014:5), in order to address the above issue, every licensed traditional midwife is required by law to give a complete record of each birth and a detailed report of all the interventions for each client. It further requires them to report to the commissioner of health and to the board any maternal, foetal, or neonatal mortality or morbidity. This Statute also outlines clear disciplinary actions and reporting procedures to be followed.

3.3.5.5 Investigation and disciplinary hearings

Investigation is related to a report lodged against a traditional midwife who is alleged to have committed a particular misconduct or malpractice (Canada Health Professions Act, 2008:6; State of Minnesota, 2014:6; United Kingdom Health Professions Council, 2003). The report is lodged by a complainant from the public, employer, police or regulators of other health professions with the relevant regulatory body, for the traditional midwife to be disciplined. Reporting will be followed by an investigation where the alleged parties and the complainant will be interviewed to establish all the relevant facts. On completion of a preliminary investigation, an informal or formal hearing will be conducted into the matter (Johnstone & Kanitsaki, 2005:364; Nursing Council of New Zealand, 2012; United Kingdom Health Professions Council, 2003).

Legislation needs to specify who can make an allegation and referral to the council about a person’s fitness to practise, the type of offences to be charged and the disciplinary processes to be followed (ICN, 2007:18). The participants mentioned the need for investigations and disciplinary processes to be conducted when malpractice has occurred.

“Traditional midwives who get involved in any malpractices should be disciplined.”(RN1)

“The mismanagement has to be reported to the chief and the counsellors so that the issue is investigated. The culprit should be disciplined and sued.”(TM9)
“.....because the traditional midwives do not have the regulatory body, there have never been any disciplinary processes undertaken.”(RN8)

“Those that perform malpractices should be disciplined, and the traditional midwives should be part of the traditional Council that will regulate and monitor their practice to ensure that proper action is taken at all times.”(RN2)(RN7)(TM10)

“If there would be responsible people who would be charged with the responsibility to investigate the incidences when there have been reported malpractices.”(RN3)

In the Canada Health Professions, (2008:6) and in the State of Minnesota in the United States of America (2014:4-6), there is provision for disciplinary action against traditional midwives who committed a malpractice or incurred a liability insurance charge, and such a person would be required to report to the board. Termination, revocation or suspension of the licensed traditional midwife’s certification or any other appropriate disciplinary action could be taken against the licensed traditional midwife. The limitations of practice or conditions of service specify what interventions the licensed traditional midwife may not perform. In Lesotho, the LUMMHC Act (1978: 62-64) does not make provision for disciplinary action of traditional midwives in cases of malpractice.

The suggestions made by the participants are meant to strengthen the regulation of traditional midwifery practice, which will promote safe care provided by traditional midwives.

3.3.5.6 Conclusion statements regarding the suggestions related to strategies for the regulation of traditional midwifery service

This fifth theme pertains to the suggestions made by the participants which relate to strategies for the regulation of traditional midwifery in Lesotho.

The main strategies include:

- The need to get more recognition from the MOH for the traditional midwives to have clear linkages with the health centres.

- The traditional midwives need to be incorporated into the LUMMHC.
- The LUMMHC Act of 1978 needs to be revised in order to address regulation of traditional midwifery practice.
- The traditional midwives need to be registered, licensed and certificated by the regulating body –the LUMMHC.
- Provision has to be made in the LUMMHC Act of 1978 to ensure that reporting, investigation and disciplinary processes and procedures for the traditional midwives are clearly outlined.

3.4 CONCLUSION

Chapter 3 presented and discussed the findings of this study, based on individual semi-structured interviews conducted with 12 traditional midwives, nine registered nurses and five members of the LUMMHC. Five themes were identified and discussed, supported by relevant direct quotations from participants' individual transcripts, and compared and contrasted with related literature findings. The researcher did not generalise the findings as the study was contextual in nature, instead the conclusion statements of each theme were provided. During discussions, the extracted quotations of the three stakeholder groups were integrated. The proposed strategies for strengthening the regulation of traditional midwifery practice will be discussed in Chapter 4 together with the study's limitations and recommendations.

CHAPTER 4

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

The research findings were presented and discussed in the previous chapter. The conclusions are based on the findings presented in the previous chapter. In this chapter, recommendations, based on the conclusions of the study, will be suggested to strengthen the regulation of traditional midwifery practice in Lesotho. Limitations of the current study will also be identified.

Chapter 4 deals with the fourth objective of this study, namely to explore strategies that could be used to regulate traditional midwifery practice in Lesotho. Such regulation could harness all available resources to the benefit of the community, and to promote safe patient care, specifically at PHC level where traditional midwives make their contributions.

The research questions related to the exploring and describing of the perceptions of traditional midwives, members of the LUMMHC and registered nurses responsible for supervising the traditional midwives, regarding the regulation of the traditional midwives in Lesotho. Data were collected by conducting semi-structured individual interviews with 12 traditional midwives, nine registered nurses and five members of the LUMMHC. The strategies are based on the conclusive statements of the five themes identified during data analysis as discussed in Chapter 3. However, the researcher did not generalise the findings as the study was contextual in nature.

The following five themes emerged as strategies for strengthening the regulation of traditional midwifery practice: perceptions of traditional midwifery practice, perceptions of roles of other role players to improve the practice of traditional midwives, perceived needs to improve the practice of traditional midwives, perceptions of role players regarding the regulation of traditional midwifery practice, suggestions related to strategies regarding the regulation of traditional midwifery.

4.2 CONCLUSION STATEMENTS: THE BASIS FOR FORMULATING PROPOSED GUIDELINES REGARDING THE REGULATION OF TRADITIONAL MIDWIFERY PRACTICE IN LESOTHO

The researcher formulated conclusion statements based on the five themes established from the findings during data analysis procedures.

4.2.1 Conclusion statements for theme 1: The perceptions of traditional midwifery practice

This theme was categorised into positive and the negative perceptions as they both relate to the practice of traditional midwives. The main perceptions were:

- Some pregnant women prefer to deliver their babies at home and to be assisted by traditional midwives who observe their cultural values and traditions.
- Traditional midwives make a valuable contribution in the communities and within the health sector, as they save lives in rural communities living in the hard-to-reach areas.
- Traditional midwifery practices continued even though they had not been encouraged in Lesotho.
- Traditional midwifery practices might expose the pregnant woman, the new-born child and the traditional midwives to infections, therefore these risky practices need to be regulated.

4.2.2 Conclusion statements for theme 2: The perceptions of roles of other role players to improve the practice of traditional midwifery

This second theme relates to perceptions of the roles of other role players to improve the practice of traditional midwives. Such role players are the registered nurses, the members of the LUMMHC; and other role players including the LMOHSW, the traditional healers, the chiefs and the counsellors.

- The registered nurses provide a supervisory role to the traditional midwives.
- Supportive action is taken by the registered nurses, the chief and the counsellors when the deliveries conducted by the traditional midwives are reported to the health centre.
- The role of a registered nurse is to ensure that the traditional midwives provide safe care through ensuring that traditional midwives receive adequate training and supervision.
- The role of the LUMMHC is to regulate the traditional healers. The LUMMHC Act of 1978 does not make any provision to address traditional midwifery practice and there are no legal mechanisms to be implemented when misconduct has occurred. Therefore, there is a need to incorporate the traditional midwives in the 1978 LUMMHC Act.
- The role of the MOH is to provide support through provision of resources and training, and by recognising traditional midwives by integrating them into the health system.

4.2.3 Conclusion statements for theme 3: The perceived needs to improve the practice of traditional midwives

This third theme addresses the perceptions of the relevant stakeholder groups towards the perceived needs to improve the practice of traditional midwives.

- There is a need to train traditional midwives to acquire knowledge and skills in order to provide safe care.
- There should be training manuals/guidelines to guide the practice of traditional midwives.
- There is a need to provide traditional midwives with resources like birth and newborn kits and gloves in order to protect themselves, the pregnant woman and her baby against exposure to infection.
- There is a need for traditional midwives to refer patients timeously to avoid serious complications which might result from delayed referrals. Referrals can be effective

because of the waiting shelters that had been built at hospitals/clinics throughout Lesotho.

- There is a need to use ambulances, local taxis or bicycles to attend to emergencies as some of the areas have poor roads and some women might have to travel long distances to reach a clinic or a hospital.
- There is a need to establish linkages between traditional midwives and the MOH in order to ensure strong collaboration between traditional midwifery practice and Western medicine. This collaboration will benefit the community as a whole as those in disadvantaged areas will receive timely care.

4.2.4 Conclusion statements for theme 4: Perceptions of role players concerning the regulation of traditional midwives

The fourth theme narrates the perceptions of the role players regarding regulation of traditional midwifery practice. These role players are referred to as the traditional midwives, registered nurses and the members of the LUMMHC.

- Traditional midwives were aware that they are not regulated; therefore they felt that there was a need to be regulated.
- No members of any of the three stakeholder groups had heard of any law regulating traditional midwives. Therefore, they felt that there was a need for the traditional midwives to be regulated to ensure that legal action could be instituted against those with reported malpractices.
- The members of the LUMMHC were willing that the LUMMHC Act of 1978 be revised in order to incorporate traditional midwives.

4.2.5 Conclusion statements for theme 5: Suggestions related to strategies for the regulation of traditional midwifery practice

This fifth theme gives a narrative of the participants' suggestions relating to strategies for the regulation of traditional midwifery in Lesotho.

The main strategies included:

- The need to get more recognition from the MOH for the traditional midwives to have clear linkages with the health centres.
- The traditional midwives need to be incorporated into the LUMMHC.
- The LUMMHC Act of 1978 needs to be revised to address the regulation of traditional midwifery practice.
- The traditional midwives need to be registered, licensed and certificated by the regulating body - the LUMMHC.
- Provision has to be made in the LUMMHC Act of 1978 to ensure that reporting, investigation and disciplinary processes and procedures for traditional midwives are clearly outlined.

4.3 CONCLUSIONS

The stakeholder groups indicated that there was a need for a pregnant woman to choose whether to deliver her baby at the health facility or at home. The traditional midwives need to be given an opportunity to assist with deliveries at home, but, they should be supported with training and equipment, as was done previously. The country needs traditional midwives, because of the country's poor road infrastructure and economic situation which make it difficult for some pregnant women, particularly those living in hard-to-reach mountainous rural areas, to reach health centres timeously.

They further perceived that the MOH should recognise the contributions made by the traditional midwives within the health system and provide resources and training to traditional midwives. Registered nurses need to supervise and collaborate with traditional midwives, for the benefit of clients residing in the remote areas of Lesotho. The LUMMHC need to revise the 1978 LUMMHC Act to incorporate traditional midwives to regulate their practice through registration, licensing, assessing their competence to practise and disciplining those with reported malpractices.

This initiative would therefore be for the improvement of the health care system within the Berea district, which needs further research in other districts in order to address it as a national issue, and which will then benefit the country as a whole. In order to improve

on the services provided by traditional midwives, they should be instructed to observe timely referrals at all times in order to avoid serious complications which could result from delayed referrals. Pregnant women should be encouraged to use the waiting areas at health facilities where they are easily monitored throughout the last two weeks of pregnancy, enabling obstetric emergencies to be diagnosed and treated timeously. Lesotho with 75% mountainous areas and with poor roads should use ambulances, local taxies or bicycles to transport emergencies to hospitals, in order to attend to those women who live in remote areas and have to travel long distances to reach health facilities.

4.4 LIMITATIONS OF THE STUDY

- The researcher did not have a prolonged engagement with the participants as the interviews were individual semi-structured interviews, conducted for 30-45 minutes, and the researcher was not able to spend more time with the participants.
- Some registered nurses and the members of the LUMMHC responded partly in Sesotho even though their interview schedules were prepared and approved in English. They were able to express themselves better and their responses were not translated but analysed directly from Sesotho by Sesotho speakers to protect the scientific integrity, as some of the meaning could get lost if translated from the original language use. Sample of original transcripts are included as Annexures I, J and K, of this dissertation, and other original transcripts will be availed for readers to check if they want to so.
- Data collection took place through individual semi-structured interviews only. Thus merely the perceptions of the three groups of participants could be portrayed. Traditional midwives' practices were not observed. The supervision and training provided by registered nurses were also not observed.
- No records of alleged instances of malpractice committed by traditional midwives could be obtained.
- No interviews were conducted with women who delivered their babies at home during the preceding 12 months to ascertain why they opted for home deliveries.

- No interviews were conducted with rural women who delivered their babies in health facilities during the preceding 12 months to determine why they preferred institutional deliveries.
- No interviews were conducted with women who used the waiting shelters nor with women who refused to use these shelters during the two weeks preceding their babies' births.
- The MOH authorities were not included in the study because they are not directly involved in regulation of traditional midwives.
- The study should have been conducted as a bigger quantitative survey because it is a national issue, but due to financial constraints and time limitations. It was not feasible to include the ten districts of Lesotho. The study findings also could not be generalised for the whole country. They can only apply to Berea district.

4.5 RECOMMENDATIONS

The findings of this study identified a number of issues that could be valuable for the regulation of traditional midwifery practice, including revising the LUMMHC Act of 1978 to incorporate traditional midwives. The LUMMHC will then be mandated to oversee all issues related to traditional midwifery practice requiring them to establish clear and strong linkages with the MOH, the registered nurses responsible for supervising, guiding and supporting the traditional midwives.

Based on the conclusions of the current study, the following recommendations are made for the LMOHSW, the LUMMHC, traditional midwifery practice, and future research in the other nine districts to obtain a national view.

4.5.1 Recommendations for the Ministry of Health and Social Welfare

Strengthening linkages and collaboration between the LMOHSW and the traditional midwives will enable the LMOHSW to recognised, support, supervise and regulate traditional midwifery practice, and to consider strategies to be used in order to provide the necessary resources required to promote safe care and to prevent spreading infections to the traditional midwives and their clients.

- There is need for policy-makers to review and revise the LUMMHC Act of 1978 in order to develop the regulations governing the scope of practice of traditional midwives in Lesotho.
- National policies should be developed pertaining to the regulation of traditional practices (Kasilo & Trapsida, 2010:25).
- In order for Lesotho to achieve high coverage in rural communities, the available workforce, terrain, infrastructure, and political will should be addressed.
- Access to transportation and communication are critical to improve maternal and infant outcomes (Kabayambi, 2013:2; Prata *et al.*, 2011:82). Major contributing factors to maternal deaths are delays in recognising danger signs, deciding to seek care, reaching care, and receiving care at health facilities. Therefore, these are health system components that need to be addressed by the governments.
- Transportation and referral systems need to be user-friendly and accessible to all the communities in order to get the appropriate level of care in case of complications/emergencies should be established as a matter of urgency.
- Health facilities need to create more culturally acceptable and respectful ways to care for pregnant women and their newborn babies.
- Health care providers should facilitate women's access to skilled traditional midwives by ensuring that traditional midwives are welcome to accompany pregnant women to health centres and that their knowledge and skills are incorporated into formal maternal and child health provision.
- There is need to strengthen collaboration between the MOH and the traditional health practice in order to facilitate effective collaboration between traditional and conventional health practitioners that will improve working relations between the two parties to ensure that attendance of pregnant women at community level is made by the registered nurses working at health centres and the skilled traditional midwives under the supervision and training of the registered nurses.

- There is need to improve communication between the MOH and the traditional health practice, health infrastructure and health services personnel in Lesotho in order to promote access to health services.
- Lesotho needs to develop a rapid response system where the district hospitals and local health centres are linked by two-way radio communication.
- There is need to integrate traditional medicine into the health sciences' curricula for the benefit of the traditional midwives working together with the health professionals. Therefore, there is need for the health professionals to be knowledgeable about the proper use of traditional/herbal practices in order to provide proper supervision by observing the community's cultural and religious values, and ensuring that risks are avoided at all times. Lesotho can adopt and adapt the WHO training tools in traditional medicine and PHC to their training programmes, syllabi and curricula.
- There is need to facilitate for exchange of country experiences on integration and strengthening collaboration between traditional medicine and the MOHSW, and the institutionalisation of traditional medicine in health systems.
- Strengthen national multidisciplinary and multisectoral mechanisms to support the implementation of traditional midwifery policies and regulatory frameworks and actively collaborate with all partners, such as the LUMMHC, in the implementation.

4.5.2 Recommendations for the Lesotho Universal Medicine Men and Herbalist Council

The following recommendations could be used as strategies that could strengthen the regulation of traditional midwifery practice in Lesotho:

- Revise an already existing national regulatory framework to incorporate the traditional midwives and enable them to practise in a variety of settings, including institutional and non-institutional, public and private institutions. The national regulatory framework needs to provide for registration, licensing, education standards and competence to practice. It is through these four core areas of responsibility that traditional midwifery practice will be regulated and the public protected.

- The legal framework should also include minimum requirements for traditional midwifery practice so that only registered traditional midwives would be granted licenses to practise.
- There is a need to develop guidelines for licensing and minimum standards for traditional midwifery practice.
- Develop the minimum standards for traditional midwifery practice which include:
 - Define the traditional midwife;
 - Define the traditional midwifery services;
 - Define the transfer of care offered by a traditional midwife;
 - Define and outline the clear criteria in defining the scope of practice of a traditional midwife (Australia National Nursing & Nursing Education Taskforce, 2006:1-5);
 - Define and outline the unauthorised services;
 - Define and outline the limits or conditions on services and restricted activities;
 - Define and outline the practice standards towards patient care, regulations, and maintaining client records and client data;
 - Define and outline the limitations of practice;
 - Define and outline the reporting processes and procedures to be followed;
 - Define and outline the offences, investigatory, disciplinary and appeals processes and procedures to be followed to a person who violates the law;
 - Define the penalties for persons who violate the law;
 - Define the persons authorised to use the title, and those prohibited from practicing;
 - Define and outline the licensure requirements for traditional midwives, and license renewal requirements (including the continuing education requirements) (Canada Health Professions Act, 2008:1-8; ICN, 2007; Queensland Nursing Council, 2000:2; State of Minnesota, 2014:1-27).
- Develop the national code of ethics, practice and conduct to ensure safety, discipline, efficacy and quality of traditional midwifery practices. The national code of ethics should spell out the fundamental responsibilities of the traditional midwives in providing care to the client, the family and the community, and coordinate their

services with those of health professionals through clear lines of communications and structures in place.

- The traditional midwives' discipline processes should be appraised on the attitudinal considerations of a good character (see figure 4.1) informing determinations of a disciplinary panel to ensure that they have accepted the responsibility for their conduct (Johnstone & Kanitsaki, 2005:367).

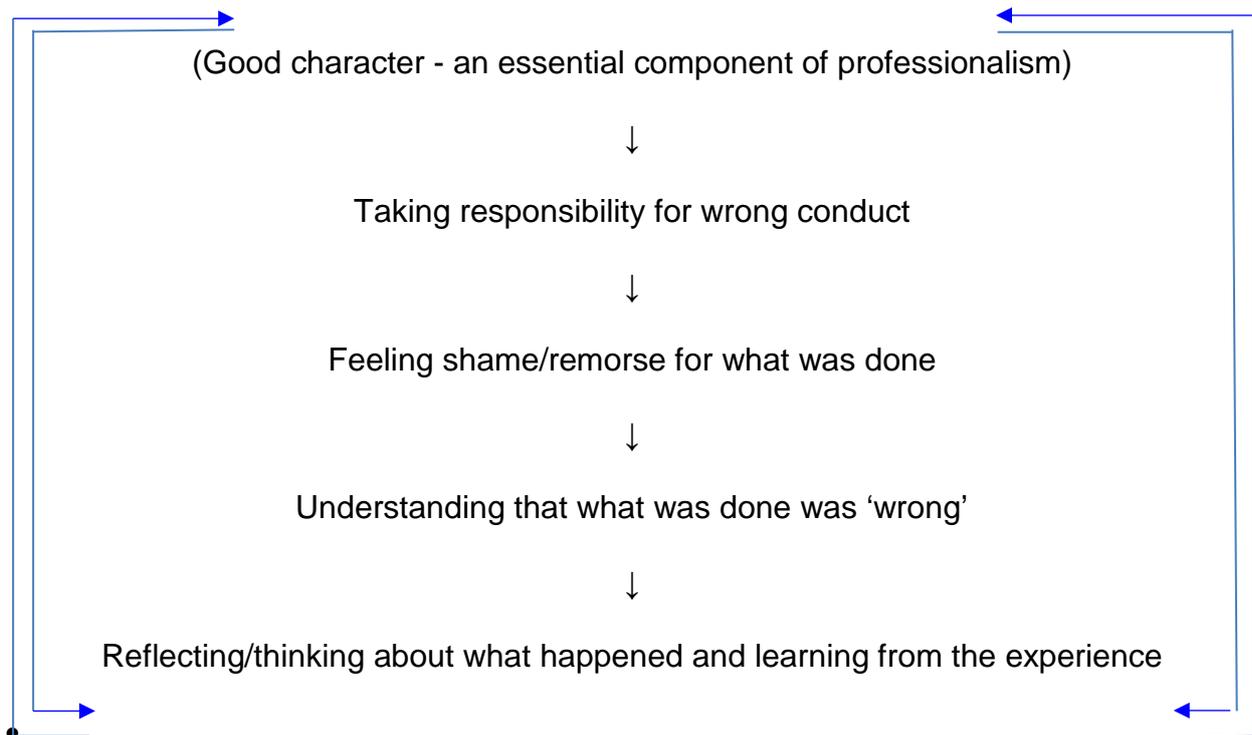


Figure 4.1: Characteristics of “good character” (Johnstone & Kanitsaki, 2005:367)

- The determination of the disciplinary panel disciplining a person is influenced by the alleged persons who have insight into and understand the wrongness of their conduct; accept responsibility for their conduct, exhibited contrition during the hearing and being honest in their demeanour (Johnstone & Kanitsaki, 2005:367).

4.5.3 Recommendations for traditional midwifery practice

There is a need to make strategies that could strengthen regulation of traditional midwifery practice in order to ensure that dangers related to traditional midwifery practices are eliminated, and safe care is provided at all times. Accurate records should be kept of all home births. Identified shortcomings should be addressed during in-service training sessions to prevent similar problems in future.

4.5.3.1 Practice

- Establish mechanisms for the protection of the cultural rights.
- The community is responsible for seeking for help (communication) in time, to the skilled personnel and the registered nurses at health centres.
- The consumers need to be taught about the proper use of traditional/herbal practices and of traditional midwives to avoid any risks.
- All women need access to women-friendly health services that meet established criteria for quality. The women friendly services need to be: Available, accessible and affordable: located as close as possible to where women live, open at convenient hours and reasonably priced for both clients and the healthcare system;
- Provide care with the highest possible technical standards, including infrastructure, infection control, written protocols and necessary supplies and equipment;
- Ensure the satisfaction of both users and providers through support and motivation of providers, client involvement in decision making, and provider responsiveness to the cultural and social norms; and
- Respect women's rights to information, choice, safety, privacy and dignity (Donnay, 2000:95).

4.5.3.2 Training

- There is need to develop a curriculum for traditional midwives and train them to attend to emergencies. Initial training should be followed by continuing education or refresher trainings.
- Integrate traditional midwifery services with clinic and hospital services to increase access to health care (Donnay, 2000:95).

- There is a belief that even if Lesotho trains the traditional midwives, education will not help because there are no resources.”

4.5.4 Research

The study on strengthening regulation of traditional midwifery practice is very limited in Lesotho and other SSA countries which face similar challenges. Limited research data on safety, efficacy and quality of traditional medicine seem to exist, indicating the dire need for conducting further research in this field. Therefore, there is need to include the traditional medicine research and development in the national health research agenda, and link them with health services and policy makers to facilitate the utilisation of research results (Kasilo *et al.*, 2010:14; Kassaye *et al.*, 2006:127).

Replication of this study in a bigger context of Lesotho and in different parts of the country could give a clearer picture of the experiences and strategies on the regulation of traditional midwifery practice in Lesotho.

The study has illuminated a number of related issues that are recommended for further scientific investigation:

- Experiences of registered nurses towards past training of traditional midwives.
- Effects of discipline on standards performance.
- Effects of cultural practices on the health of Basotho as consumers of care.
- Evaluation of nurses’ performance towards standards compliance in Lesotho.
- Effects of regulation on performance standards within various categories of health professionals.
- Professional nurses’ perceptions on continuing professional development for traditional midwives.

4.6 FINAL CONCLUSIVE COMMENTS

This study aimed to develop strategies that would strengthen the regulation of traditional midwifery practice in Lesotho. After the completion of the study a set of strategies

recommended to the LMOHSW and the LUMMHC for possible implementation to improve the regulation of traditional midwifery practice in Lesotho was provided.

The study findings have recommended the need to support strengthening regulation of traditional midwives through training, supervision and development of effective regulatory systems as it is believed that regulation would promote safe patient care at community level (PHC) where access to health facilities is compromised due to the topography of the country (rough mountainous terrain and lack of roads), which cannot be changed to suit the country needs.

Regulation would promote accountability of the traditional midwives for care provided in hard-to-reach areas where professional health care is inaccessible; hence the need to reduce the liability of registered nurses to account for maltreatments or deaths of traditional midwives' clients. Improvement in traditional midwifery regulation would also advance best practices, and enforce compliance with the developed standards to guide traditional midwifery practice. Regulation would also help to make traditional midwives who provide unsafe care, be accountable and provide a platform for disciplinary procedures when the need arises. It has also been shown that even though traditional midwives practice has not been encouraged, some of the community members still value the traditional midwives practice due to the cultural, religious and societal influences which cannot be ignored. Furthermore it has been established that it is pertinent for Lesotho to strategically consider working collaboratively and making plans that will ensure that there is proper utilization of available resources in order to ensure that the country harnesses all available resources to benefit the community

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HSS see Lesotho HSS project

ICF see Intermediate Care Facilities

ICN see International Council of Nurses

International Council of Nurses. 2012. The International Code of Ethics for nurses. <http://www.icn.ch/who-we-are/code-of-ethics-for-nurses/> Date of access: 10 Dec 2013.

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ANNEXURE A: ETHICS APPROVAL



NORTH-WEST UNIVERSITY
YUNIBESITHI YA BOKONE-BOPHIRIMA
NORDWES-UNIVERSITEIT

Private Bag X8001, Potchefstroom
South Africa 2520

Tel: (018) 299-4900
Faks: (018) 299-4910
Web: <http://www.nwu.ac.za>

Institutional Research Ethics Regulatory Committee

Tel +27 18 299 4849
Email Ethics@nwu.ac.za

ETHICS APPROVAL CERTIFICATE OF PROJECT

Based on approval by Health Research Ethics Committee (HREC), the North-West University Institutional Research Ethics Regulatory Committee (NWU-IRERC) hereby approves your project as indicated below. This implies that the NWU-IRERC grants its permission that, provided the special conditions specified below are met and pending any other authorisation that may be necessary, the project may be initiated, using the ethics number below.

Project title: Strengthening regulation of traditional midwifery practice in Lesotho.	
Project Leader: Dr CS Minnie	
Ethics number:	N W U - 0 0 1 7 6 - 1 5 - A 1
	<small>Institution Project Number Year Status</small>
	<small>Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation</small>
Approval date: 2015-10-20	Expiry date: 2016-11-30
Risk	Minimal

Special conditions of the approval (if any): None

General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following:

- The project leader (principle investigator) must report in the prescribed format to the NWU-IRERC:
 - annually (or as otherwise requested) on the progress of the project,
 - without any delay in case of any adverse event (or any matter that interrupts sound ethical principles) during the course of the project.
- The approval applies strictly to the protocol as stipulated in the application form. Would any changes to the protocol be deemed necessary during the course of the project, the project leader must apply for approval of these changes at the NWU-IRERC. Would there be deviations from the project protocol without the necessary approval of such changes, the ethics approval is immediately and automatically forfeited.
- The date of approval indicates the first date that the project may be started. Would the project have to continue after the expiry date, a new application must be made to the NWU-IRERC and new approval received before or on the expiry date.
- In the interest of ethical responsibility the NWU-IRERC retains the right to:
 - request access to any information or data at any time during the course or after completion of the project;
 - withdraw or postpone approval if:
 - any unethical principles or practices of the project are revealed or suspected,
 - it becomes apparent that any relevant information was withheld from the NWU-IRERC or that information has been false or misrepresented,
 - the required annual report and reporting of adverse events was not done timely and accurately,
 - new institutional rules, national legislation or international conventions deem it necessary.

The IRERC would like to remain at your service as scientist and researcher, and wishes you well with your project. Please do not hesitate to contact the IRERC for any further enquiries or requests for assistance.

Yours sincerely

Linda du
Plessis

Digitally signed by Linda du Plessis
DN: cn=Linda du Plessis, o=NWU,
ou=Vaal Triangle Campus,
email=Linda.duplessis@nwu.ac.za,
c=ZA
Date: 2015.10.26 16:40:56 +0200

Prof Linda du Plessis
Chair NWU Institutional Research Ethics Regulatory Committee (IRERC)



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Web: <http://www.nwu.ac.za>

Ethics Office
Tel: 018-299 2092
Fax: 018-299 2088
Email: Minrie.Greeff@nwu.ac.za

20 October 2015

Dr CS Minnie
INSINQ

Dear Dr Minnie

HREC APPROVAL OF YOUR APPLICATION

Ethics number: NWU-00176-15-S1

Kindly use the ethics reference number provided above in all correspondence or documents submitted to the Health Research Ethics Committee (HREC) secretariat.

Project title: Strengthening regulation of traditional midwifery practice in Lesotho

Project leader/supervisor: Dr CS Minnie

Student: F Moetsana-Poka

Application type: Full Single

Risk level descriptor: Minimal

You are kindly informed that at the meeting held on 15/07/2015 of the HREC, Faculty of Health Sciences, the aforementioned was approved.

The period of approval for this project is from 20/10/2015 to 30/11/2016.

After ethical review:

Translation of the informed consent document to the languages applicable to the study participants should be submitted to the HREC (if applicable).

The HREC requires immediate reporting of any aspects that warrants a change of ethical approval. Any amendments, extensions or other modifications to the protocol or other associated documentation must be submitted to the HREC prior to implementing these changes. Any adverse/unexpected/unforeseen events or incidents must be reported on either an adverse event report form or incident report form.

A progress report should be submitted within one year of approval of this study and before the year has expired, to ensure timely renewal of the study. A final report must be provided at completion of the study or the HREC must be notified if the study is temporarily suspended or terminated. The progress report template is obtainable from Carolien van Zyl at

Carolien.VanZyl@nwu.ac.za. Annually a number of projects may be randomly selected for an external audit.

Please note that the HREC has the prerogative and authority to ask further questions, seek additional information, require further modification or monitor the conduct of your research or the informed consent process.

Please note that for any research at governmental or private institutions, permission must still be obtained from relevant authorities and provided to the HREC. Ethics approval is required BEFORE approval can be obtained from these authorities.

The HREC complies with the South African National Health Act 61 (2003), the regulations on Research with Human Participants of 2014 of the Department of Health and Principles, the Declaration of Helsinki, 2013, the Belmont Report and the Ethics in Health Research: Principles, Structures and Processes (SANS document).

We wish you the best as you conduct your research. If you have any questions or need further assistance, please contact the Ethics Office at Carolien.VanZyl@nwu.ac.za or 018 299 2089.

Yours sincerely



Prof Minnie Greeff
HREC Chairperson

Current details: (13210572) C:\Users\13210572\Documents\HREC\HREC - Applications\2015 Applications\Applications 06 - 15 July 2015\NWU-00178-15-81 (CS Minnie-F Moetsane-Polok)\NWU-00178-15-81 (CS Minnie-F Moetsane-Polok) - AL\NWU-00178-15-81 (CS Minnie-F Moetsane-Polok) - AL.docm
20 October 2015

File reference: 9.1.5.3

ANNEXURE C Approval letter from the Ministry of Health



Ministry of Health
PO Box 514
Maseru 100

REF: ID87-2015

Date: 17 February 2016

To:

Flavia Moetsana-Poka
MPH candidate
North West University
North West, RSA

Category of Review:

- Initial Review
 Continuing Annual Review
 Amendment/Modification
 Reactivation
 Serious Adverse Event
 Other _____

Dear A. Benjamin Nwako

RE: Strengthening regulation of traditional midwifery practice in Lesotho (ID 87-2015)

This is to inform you that on 12 February 2016 the Ministry of Health Research and Ethics Committee reviewed and **APPROVED** the above named protocol and hereby authorizes you to conduct the study according to the activities and population specified in the protocol. Departure from the approved protocol will constitute a breach of this permission.

This approval includes review of the following attachments:

- Protocol version 11 December 2015
 English consent forms
 Sesotho consent forms
 Data collection forms
 Participant materials
 Other materials:

This approval is **VALID** until 11 January 2017.

Please note that an annual report and request for renewal, if applicable, must be submitted at least 6 weeks before the expiry date.

All serious adverse events associated with this study must be reported promptly to the MCH Research and Ethics Committee. Any modifications to the approved protocol or consent forms must be submitted to the committee prior to implementation of any changes.

We look forward to receiving your progress reports and a final report at the end of the study. If you have any questions, please contact the Research and Ethics Committee at rcumoh@gmail.com (or) 22226317.

Sincerely,

Dr. Nyane Letsie
Director General Health Services (a.i.)

Mrs. V.T. Lehana
Chairperson National Health-Institutional Review Board (NH-IRB)

ANNEXURE D: Interview schedules

INTERVIEW SCHEDULE FOR TRADITIONAL MIDWIVES

The central questions posed to the traditional midwives were:

Can you please tell us your experiences regarding the Lesotho Universal Medicine Men and Herbalist Council's current systems regarding regulation of traditional midwifery practice in Lesotho?

Can you tell us your perceptions about the roles of the Lesotho Universal Medicine Men and Herbalist Council towards patient safety when providing traditional midwifery services?

What actions are taken by the Lesotho Universal Medicine Men and Herbalist Council in cases where there have been any kinds of mismanagement or putting a patient's life at risk during provision of traditional midwifery care?

How can regulation help to improve traditional midwifery practice in order to promote safe care?

Interview schedule translated in Sesotho:

Ke kopa u ko re qoqele ka litsebo tsa hau malebana le ts'ebetso ea lekhlotla la lona la Lesotho Universal Medicine men and Herbalist Council hore na lits'ebeletso tsa bona li joang malebana le ho laola tsebetso ea bapepisi metseng ka hare ho naha ea Lesotho?

Ke kopa u re joetse maikutlo a hao malebana le boikarabello boo lekhlotla la lona la Lesotho Universal Medicine men and Herbalist Council le lokelang ho bo etsa malebana le tsébetso e sireletsehileng ea bapepisi metseng?

Ke mehato efe eo lekhlotla la Lesotho Universal Medicine Men and Herbalist Council le e nkang malebana le ts'ebeletso e bohlasoa mosebetsing oa lona bapepisi metseng, e behang bophelo ba mokuli tsietsing?

Ke kopa u ko re joetse maikutlo a hao hore na u bona eka ke lintho life malebana le taolo ea bapepisi metseng, e ka etsoang ho thusa ho ntlafatsa ts'ebetso ea bapepisi le polokeho ea sechaba.

The interviews with the traditional midwives were conducted in Sesotho because that is the official language, and because of their low level of education. They were more fluent in Sesotho. The transcriptions were translated into English by the researcher, and were then verified by the research expert and the independent co-coder.

Interview schedule for registered nurses

- Can you please tell us about your perceptions regarding the regulation of traditional midwifery practice in instances where there have been reported malpractices from the community?
- Are there any legal actions taken against a traditional midwife with a reported malpractice? If yes, what kind of actions are taken, and by whom?
- What are the responsibilities of the traditional midwives towards providing safe patient care?
- What do you think are the strategies/approaches that could be taken to strengthen the regulation of traditional midwifery practice?

The above interview questions were not translated in Sesotho because all the registered nurses were fluent in English as their work language, and their level of education is higher than that of the traditional midwives. Some registered nurses responded partly in Sesotho because they expressed themselves better. The responses were not translated but analysed directly from Sesotho, and some of the interviews were analysed directly from Sesotho by Sesotho speakers to protect the scientific integrity, as some of the meaning could get lost if translated from the original language use. The sample of the original transcripts is annexed (see Annexures J,K,L), and some other original transcripts will be availed for readers to check if they want to.

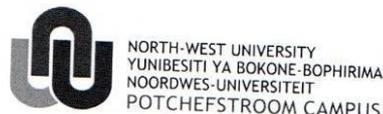
Interview schedule for members of the Lesotho Universal Medicine Men and Herbalist Council

- Can you please tell us about your role regarding the regulation of traditional midwifery practice, and any legal mechanisms you have in place?
- What action is taken in situations where any kind of traditional midwifery malpractice has been reported?
- What do you think are the strategies/approaches that could be used to strengthen the regulation of traditional midwifery practice by ensuring that patient safety is met at all times, and proper action is taken against those with reported malpractices?

The above interview questions were also not translated in Sesotho because all the members of the LUMMHC were fluent in English as their official language. Some participants responded partly in Sesotho because they expressed themselves better. Some of the interviews were analysed directly from Sesotho by Sesotho speakers to protect the scientific integrity, as some of the meaning could get lost if translated from the original language use. The sample of the original transcripts is annexed (see Annexure J,K,L), and some other original transcripts will be availed for readers to check if they want to.

The central questions for each stakeholder group were followed by probing questions, depending on the participants' responses to encourage further communication and facilitate the flow of information.

**ANNEXURE E: Information leaflet and consent form for traditional midwives
(ENGLISH AND TRANSLATED IN SESOTHO)**



**PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM
FOR TRADITIONAL MIDWIVES**

**TITLE OF THE RESEARCH PROJECT: STRENGTHENING REGULATION OF
TRADITIONAL MIDWIFERY PRACTICE IN LESOTHO**

REFERENCE NUMBERS: NWU-00176-15-S1

PRINCIPAL INVESTIGATOR: FLAVIA MOETSANA-POKA

ADDRESS: P. O. BOX 9110, MASERU 0100, LESOTHO

CONTACT NUMBER: (+266) 58043999 OR (+266) 63944145

You are being invited to take part in a research project that forms part of my study on "Strengthening regulation of traditional midwifery practice in Lesotho," with the aim of strengthening control of traditional midwifery practice in order to improve parameters which would promote safe practice. Please take some time to read the information presented here, which will explain the details of this project. Please ask the researcher any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the **Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University (NWU-00176-15-S1)** and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki and the ethical guidelines of the National Health Research Ethics

Council. It might be necessary for the research ethics committee members or relevant authorities to inspect the research records.

What is the research study all about?

This study will be conducted in one of the ten districts in Lesotho and will involve semi-structured interviews with the experienced health researchers trained in conducting interviews, collect data through audio recorder, field notes and transcribed verbatim; then, the researcher will independently analyse the transcribed data and field notes with the use of the analysis guide. The traditional midwives, registered nurses and members of the Lesotho Universal Medicine Men and Herbalist Council will be participants in the study.

The objectives of this research are:

- Explore and describe the perceptions of traditional midwives regarding regulation of their practice.
- Explore and describe the perceptions of members of the Lesotho Universal Medicine men and Herbalists Council regarding regulation of traditional practice.
- Explore and describe the perceptions of registered nurses responsible for supervising traditional midwives regarding regulation of their practice.
- Explore strategies that can be used to regulate traditional midwifery practice.

Why have you been invited to participate?

- You have been invited to participate because you are a mature woman, culturally accepted and respected by your community, more experienced and up to date with knowledge and skills in providing traditional midwifery care, and your perceptions are very valuable to us (researchers).

What will your responsibilities be?

If you agree to take part in this study, you will be expected to respond to the interview questions, and you will be involved in the research process throughout the study to ensure trustworthiness.

I would like you to give a written consent at your own will, to take part in my study, but the first step will be to provide you with a detailed verbal and written explanation about the purpose of the study, its significance, benefits and any risks that would result from the study. All this information will be provided in a language that you are comfortable with or prefer most; and you are free to bring along your relatives to understand clearly the information given. You will be allowed to take your time; a day or so, to make your own decision whether you approve to take part in the study or not; and it is your right to agree or disagree without any prejudice at any point in time. When you have made your decision, you will be requested to sign two copies of informed consent; and one copy will be your own copy, the other will be taken by the researcher. Illiterate participants will be requested to sign using their thumbprint or initials that everything was explained to them, and they understand all the information that was explained to them. The independent person will be asked to co-sign with the illiterate participants that the participant understands the information, and willingly made their mark.

You will be expected to get full information about the study prior to signing a voluntary written informed consent as an approval to take part in the study. It will be followed by signing an informed consent after you have had time to make your decision, and having understood and agreeing to take part in the study. You will be expected to participate in the study at your own free will, and if you decide to withdraw from the study, you are free to do so at any time during the research process, without any prejudice.

You will be expected to ensure that the researcher and the transcribe involved in the study have signed a confidentiality agreement before collection of data. You will be requested to avail yourself for the interviews with the researcher which will take 30 - 45 minutes, and you are to warn the researcher if you need to take breaks at any time to avoid being pressurised by the researcher. The interviews will be held at your home or at any place where you will feel comfortable to hold interviews. The researcher will agree with you to use the interview schedule which will be more suitable for you throughout the study.

You will be individually interviewed and asked questions in a language you prefer (either English or Sesotho), and you will be given time to express yourself in the language you are comfortable with when responding to the questions. If you don't understand a question, you are free to ask questions to the researcher; either to repeat the question or clarify the question in the language you are comfortable with or prefer.

You will be expected to ask questions to clarify any misunderstandings on the data collected and analysed to verify whether the themes developed from the interviews are true reflections of the deliberations the researcher had with the participant.

You are to get an honest report from the researcher, on the findings of the study
You will be expected to contact the North West University Ethics Committee if there are any concerns regarding the protection and non-exposure to unscientific and unethical processes of the study.

Will you benefit from taking part in this research?

The study will influence the development of guidelines and minimum standards to outline the legal responsibilities and expectations of the traditional midwives in the event of breach of instructions, maltreatment, or mishap; and to enforce compliance with the aim of protecting the public against unsafe and hazardous traditional practices.

There are no direct benefits.

The Indirect benefits for you as a participant will be

- Your roles, responsibilities and expectations as a traditional midwife will be clarified and well defined.
- Your traditional midwifery practice will be legally protected and more recognized to strengthen the linkages within the health care system, as you provide first line of care in the hard to reach areas.
- The study will expand the knowledge base on regulation of traditional midwifery practice as there is limited literature available. Local knowledge on cultural and traditional midwifery practices will be shared with other health care professionals

for the benefit of the health care system as a whole, and the public in receiving safe care.

Are there risks involved in your taking part in this study?

- Low Risk – boredom, time, hunger

What will happen in the unlikely event of some form of discomfort occurring as a direct result of your taking part in this research study?

- You will be given a break whenever you feel tired.
- You will be provided with a snack when you feel hungry. You should feel free to express yourself.
- Should you have the need for further discussions after the study as a result of any discomforts of weather at areas where the interview will be conducted an opportunity will be arranged for you to seek medical help.

Who will have access to the data?

- Anonymity will be maintained by using the numbers or alphabets as a reference to the participants during the interviews; the names of the participants will not be used and instead a unique number will be assigned to protect the participants' identity.
- Confidentiality will be ensured by ensuring that the researcher, transcribe and the co-coder who will be accessing the participants' data on audiotapes, transcripts and field notes will sign a confidentiality agreement to keep the participants' data confidential at all times, and throughout the research process. The researcher will keep all the information obtained in the locked cupboards at North West University for a period of five years, following which; the data will all be destroyed.
- Reporting of findings will be anonymous by ensuring that the researcher maintains integrity on the publication of content and present the results by avoiding use of the participants' names and locations of residence during the presentation. The researcher will ensure that any presentation made conforms to acceptable ethical practices, being honest in its content and presentation. Only the researchers and the transcribers will have access to the data as they will first sign a confidentiality agreement before accessing the data.
- Data will be kept safe and secure by locking hard copies in locked cupboards in the researcher's office and for electronic data it will be password protected. (As soon as data has been transcribed it will be deleted from the recorders.) Data will be stored for five (5) years at North West University, after which it will be destroyed.

Will you be paid to take part in this study and are there any costs involved?

No, you will not be paid to take part in the study but refreshments will be prepared for you, at the time you will need to take a break. Travel expenses will be paid for those participants who have to travel to the study site. There will thus be no costs involved for you, if you do take part.

Is there anything else that you should know or do?

- You can contact .Mrs. Flavia Moetsana-Poka at (+266) 58043999 or email - fla_mpoka@yahoo.co.uk. If you have any further queries or encounter any problems.
- You can contact the Health Research Ethics Committee via Mrs Carolien van Zyl at (+27) 018 299 2094; carolien.vanzyl@nwu.ac.za if you have any concerns or complaints that have not been adequately addressed by the researcher.

You will receive a copy of this information and consent form for your own records.

How will you know about the findings?

- The findings of the research will be shared with you by preparing research reports to disseminate the findings through publications, presentations and conferences to you as the participants who took part in the study, your colleagues and the health professionals in order to assess trustworthiness, reliability and validity of the study by ensuring that the strategies and criteria to adhere to in order to ensure rigour are addressed. The four quality criteria include credibility, transferability, dependability and conformability. The presentation of results will be to the level of your understanding.
- I will also explain the ethical points which have to be critically considered in ensuring that data is not manipulated or invented; data is not forged or stolen because I will be violating the value of veracity (truth and truth-telling). Limitations and problems encountered during the research process will be included in the report, and not concealed or ignored. Data will be honestly analysed and, interpreted without personal, political and emotional bias; and the researcher will also maintain integrity in the presentation. The researcher will declare any conflict of interest and identify any funding received for the study.
- The researcher's presentation will be clear and logical addressing the following sections below. The researcher will highlight how trustworthiness was addressed, and also identify the specific criteria used to ensure reliability and validity of a qualitative research study:

Declaration by participant

By signing below, I agree to take part in a research study entitled "Strategies to strengthening regulation of traditional midwifery practice in Lesotho"

I declare that:

- I have read this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions to both the person obtaining consent, as well as the researcher and all my questions have been adequately answered.

- I understand that taking part in this study is voluntary and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*)..... on (*date*) 20....

.....
Signature of participant

.....
Signature of witness

Declaration by person obtaining consent

I (*name*) declare that I explained the information in this document to

- I encouraged him/her to ask questions and took adequate time to answer them
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above.
- I did not use a interpreter.
- Signed at (*place*)..... on (*date*)
(Letsatsi)..... 20....

.....
Signature of person obtaining consent

.....
Signature of witness

Declaration by researcher

I (*name*) declare that I explained the information in this document to).....

- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above.
- I did not use a interpreter.

Signed at (*place*)..... on (*date*) 20....

.....
Signature of researcher

.....
Signature of witness



NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
POTCHEFSTROOM CAMPUS



PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM FOR TRADITIONAL MIDWIVES (TRANSLATED IN SESOTHO)

**TITLE OF THE RESEARCH PROJECT (SEHLOHO): BOINTLLAFATSO
TSÉBETSONG EA LEKHOTLA LA BAPEPISI METSING MAPAPI LE TAOLO EA
BAPEPISI METSENG LESOTHO**

REFERENCE NUMBERS: NWU-00176-15-S1

PRINCIPAL INVESTIGATOR: FLAVIA MOETSANA-POKA

ADDRESS: P.O.BOX 9110, MASERU 0100, LESOTHO

CONTACT NUMBER: (+266) 58043999/ 63944145

U kopuo a ho nka karolo boithutong ba ho fumana mekhoe e ka thusang ho ntlafatsa kapa ho holisa lekhotle la bapetsi metseng malebana le taolo ea tsébetso ea bona; sepheo ele ho ntlafatsa mekhoe ea tsébetso ea bapetsi, le ho bona hore ba eba le boikarabello mesebetsing ea bona. U kopuo a hore u nke nako ea hau hore u bale tokomane ena, u e utloisise, kaha ke eona e hlalosing ka botebo litaba tsa boithuto bona. U kopuo a ho botsa mofuputsi lipotso moo ebang ha u utloisise tlhaloso ka boithuto bona. Ho bohlokoa hore u utloisise ka tsela e paharalletseng litaba tsohle ka boithuto bona, le hore na karolo ea hau ke efe. Hape, karolo ea hau boithutong bona ke boikhetheho bahau, ha u qubelloe ke mang kappa mang. U na le tokelo ea ho se nke karolo, kapa ho tlohela ho tsoela pele ka ho nka karolo boithutong bona, boemong bofe kapa bofe kaha ke boikhetheho ba hau. Ho hana ho nka karolo, ho

1

keke hoa u tlisetsa litholoana tse seng monate hobane ke tokelo ea hau ho etsa joalo. U tla nne u fumane menyetla eohle joaloka batho ba bang.

Boithuto bona bo hlapantsoe ka molao ke komiti ea sekolo ea North West University, 'me boithuto bona bo tla etsoa ho ipapisitsoe le melao ea komiti ena ea boithuto.

Boithuto ke ba eng?

Boithuto bona bo etsetsoa ho fumana hore na ke mekhoa efeng e ka thusang ho ntlafatsa bosebeletsi ba lekhlotla la bapepisi metseng, naheng ea Lesotho. Bo tlo kenyeletsa lona bapepisi metseng ba sebaka sa Berea, b aka bang leshome ho isa ho leshome le metso e mehlano.

Hobaneng u khethuoe ho nka karolo boithutong boo?

U kopuo a ho nka karolo hobane u le mpopepisi oa motseng, a seng a le lilemong, a nang le litsebo tse pharalletseng mapapi le boepisi bona ba metseng, hommoho le taolo ea bona. U tla nka karolo ha feela u lumela ho etsa joalo, 'me u ke ke ua qobelloa ke mang kapa mang.

Ho lebeletsoe eng ho uena u le monka karolo:

Ha u lumela ho nka karolo boithutong bona, u tla be u lebelletsoe ho araba lipotso tseo u tla li botsoa, 'me u tla ba karolo ea boithuto bona ho tloha qalong ho fihlela qetellong; 'me pele re ka qala ho etsa mosebetsi, ke tla u fa tokomane eo ke tla be ke u kopa hore u e tekenele tokomane hammoho le paki ea hau, e le ho netefatsa hore u lumela ho nka karolo boithutong bona, kamora tlhalosetso tsohle le ho fana ka mabaka, bohlokoa, melemo le kotsi kapa tsietsi e ka bang teng malebana le boithuto bona.

U tla lumelloa ho nka nako ea hao hore u fihlele qeto e nepahetseng hore na u lumela ho nka karolo boithutong bona kapa che, 'me u tla fuoa monyetla oa hore u botse lipotso moo u sa utloisiseng ele hore u tekenele taba eo u e utloisang hantle. U se ke ua ts'aba letho malebana le qeto eo u tla e nka hobane ke tokelo ea hao ho lumela kapa ho hana ho nka karolo, 'me ke u netefaletsa u keke ua etsoa letho ekaba ka mokhoa oa ho utloisoa bohloko, kapa ho tingoa menyetla e meng e itseng malebana le qeto eo u e entseng. Ha u so entse qeto e nepahetseng kamora ho fuoa matsatsi hore u inahane, u sa susungoetsoa ke mang kapa mang, u tla kopuo a ho tekenela tokomane ena e le kananelo ea hore u batla ho nka karolo boithutong bona. Tokomane tsena li tla ba peli tseo u li tekenelang, e 'ngoe e tla ba ea hao, e 'ngoe e tla ba ea mofuputsi. Ha u sa tsebe ho ngola, u tla tekena ka monoana oa hao hammoho le paki ele ho netefatsa hore u fuoe tlhaloso eohle 'me u utloisisa sohle malebana le boithuto bona. Ho tla ba le motho a tekenang le uena ele hlapantsá hore ehlile u utloisisitse tlhaloso eo u e fuoeng, 'me ke qeto ea hao ena eo u e nkileng.

U lebeletsoe ho nka nako ea hao, u bala tokomane ena hore u e utloisise hobane e hlalositse litaba tsohle ka boithuto bona. U lebeletsoe ho botse mofuputsi lipotso moo ebang u sa utloisise ka boithuto bona, ele hore u fumane tlhalosetso e nepahetseng. Ho bohlokoa hore u utloisise ka mokhoa o hlakileng hore boithuto bona bo fupere eng, le hore na karolo ea hao ke efe. Ho nka karolo boithutong bona ke qeto ea hao, 'me u ka hana ho nka karolo kappa ho tsoela pele ka boithuto ho sa tsotellehe hore na u chenchana maikutlo bohareng ba boithuto. Ha ho na letho leo u tla hlokoletsoa ka lona kappa u tingoe menyetla e itseng ha u hana ho nka karolo.

U lubeletsoe ho khetha sebaka se u khotsofatsang ho ka phutholoha ka nako ea lipuisano.

U lebeletsoe ho botsa mofuputsi le sekolo sa North West University lipotso moo ebang ha u utloisise, ele hore u fumantsoe tlhaloso e feletseng, ele ho qoba ho se utloisisane.

U lebeletsoe ho araba lipotso tsa mofuputsi.

U lebeletsoe hore u bone hore batho bohle ba nkang karolo boithutong bona ba tekene le lipaki tokomaneng e lokelehang, eo ba itlamang hore bat la boloka litaba tsohle tse buuoeng lekunutung ka nako ea liphuputso.

Bohlokoa ba boithuto boo le menyetla ea ha oho nka karolo boithutong boo ke bofe?

Ha hona menyetla e teng hore ebe u nka karolo boithutong bona.

Bohlokoa ba boithuto boo ke bofe?

Bohlokoa ba boithuto bona ke hore bo tlo thusa lekhotla la bapepisi metseng hore na ba ka etsa meralo efe e le ho etsa litokomane tse bontsáng ka mokhoa o hlakileng hore na mosebetsi oa bapepisi ke ofe, 'me na ho lebeletsoe hore ba sebetse joang e le ho sireletsa sechaba khahlanong le tsébetso e bohlasoa, e behang maphelo a sechaba tsietsing.

Litaba tse amanang le tsébetso ea bapepisi li tla bokeletsoa 'moho e le ho thus aka ho arolelana letsebo ka taba tsa boepisi metseng le batho ba bang ba amehang ba lekala la bophelo.

Mosebetsi oa hao le boikarabello ba hao mosebetsing oa hao oa ho pepisa bakhachane o tla be u hlakile, ho na le litokomane tse hlahosang lintlha tsohle. Tsébetso ea lona ea ho pepisa bakhachane metseng e tla be e le lingoliloeng tsa molao, 'me e tla be e hlakile, e tsejoa ke basebetsi ba bang ba bophelo, e le ho otlolla bosebeletsi bo botle.

Boithuto bona bo tlo thusa sechaba sa Basotho ho utloisisa hore na taolo malebana le tsébetso ea lona ea ho pepisa metseng na ke ea mofuta ofe hobane ho fumanehile hore libuka tse nang le litaba tsa taolo ena lia fokola. Ho bohlokoa hore litsebo tsena tsa tsébetso ea bosechaba le setso sa rona li arolelanoe le mafapha a mang a basebetsi ba bophelo, e le ho utloisisa hore na tsébetso ea taolo ea boepisi e joang.

Na hona le kotsi e ka bang teng malebana le boithuto boo?

Kotsi e boemong bo tlase haholo, empa ho ka ba le bolutu kappa tlala ea ba teng, ele malebana le nako eo re tla e nka re bua le uena ka taba tsa boithuto bona.

Ho tla etsahala joang boemong boo ho ka bang le boemo bo seng monate nakong ea boithuto boo?

Bannka karolo boithutong bona ba tla fuoa nako ea ho phomola ha ba utloa ba khathetse, 'me ba lebeletsoe ho phuthuloha le ho bolela ha ba utloa ba khathetse.

Bannka karolo bat la fuoa lijo ha ba lapile, 'me ba lebeletsoe ho bolela ha ba utloa ba se ba lapile.

Haeba ho na le taba eo u tla be u hloka ho bua ka eona kamora boithuto bona, ele malebana le sebaka seo re tla be re se sebelisa bakeng sa boithuto bona, se ka tlisang maemo a seng monate a bolepi; u lokolohile hore u ka fumantsóa thuso haeba u qeteletse u ka utloa u sa phela hantle ka lebaka la sebaka kapa baa bolepi ba letsatsi leo.

Ke mang ea tla be a na le tokelo ea ho fumana kapa ho sebetsana le litaba tsee?

Mofuputsi 'moho le bathusi ba hae tlhahlobong ena ea boithuto ba tla tekenela tumellano ea hore bat la boloka litaba tsena lekunutung ka nako eohle, ho fihlela boithuto bo felile.

Boitsebiso ba hao le litaba tsohle tseo re tla li bua li tla bolokoa lekunutung ka hore ho tla sebelisoa lipalo bakeng sa ho sebelisa lebitso la hao e le ho sireletsa boitsebiso ba hao.

Ke hlapanya hore litaba tsohle tseo re tlang ho li bua ebile re li hatisa, li tla bolokoa lekunutung.

Tlaleho ea sephetho sa boithuto bona se ke ke sa eba le boitsebiso ba lona ka mokhoa ofe kapa ofe, 'me re tla qoba ka tsela tsohle ho iphumana re ka sebelisa mabitso kapa libaka tsa lona. Ke u tsépisa hore litlaleho ka boithuto ba ka li tla etsoa ho ipapisitsoe le melao ea teng. Batho ba tla ba le seabo polokelong ea litaba tsena e tla ba feela ba tekenneng tumellano ea ho boloka lekunutu. Litokomane tsohle tse nang le litaba tsa lona li tla bolokoa sekolong, ka moo hot la be ho koetsoe ka thata hore motho mang kapa mang a ka bula feela, 'me litokomane tsena li tla chesoa kamora lilemo tse leshome.

Banka karolo ba tla fuoa tlaleho ea boithuto bona ha bo se bo phethetsoe.

Ho tla etsahala joang ka litaba tse buuoeng ?

Litokomane tsohle tse nang le litaba tsena li tla tsóaroa feela ke batho ba tekenetseng boitlamo bah o boloka litaba tsena ka lekunutu, ha ba ntse ba sebetsana le tsona naheng ea Lesotho, 'me ba tla sebetsa litaba 'moho le motataisi oa bona mane North West University, ho la Afrika Boroa. Litokomane tsohle tse nang le litaba tsena li tla bolokoa moo li notleletsoeng le mofuputsi, hammoho le mane sekolong sa North West University. Litokomane tsena li tla bolokoa lilemo tse hlano, kamorao ho moo, li tla chesoa kaofela.

Na ho na le patala eo le tla e fuoa malebana le ho nka karolo boithutong boo?

Chee, ha ho na patala, empa ho na le lijo tseo le tla li lokisetsoa ka nako ea boithuto, hammoho le ho fuoa chelete ea ho palama kapa hoe a hae.

Hona le litaba tse ling tseo u ka ratang ho li botsa?

U ka kopana le "Me" Flavia Moetsana-Poka linomorong tsena (+266 58043999), kapa emailing ena fla_mpoka@yahoo.co.uk haeba u na le lipotso kappa u thulana le bothata bo bong.

U ka letsetsa komiti e faneng ka tumello boithutong bona ka ho letsetsa Mrs. Carolien van Zyl linomong tsena, (+27) 018 299 2094 kapa emailing ea carolien.vanzyl@nwu.ac.za haeba ho na le moo u sa khotsofalang teng ke moithuti

U tla tseba joang ka sephetho sa boithuto boo?

Ke tla tsebisa batho ba neng ba nkile karolo litaba tsa sephetho sa boithuto ka ho ngola lipampiring, le ho bua ka tsona kapa ho ruta ka tsona likopanong, e le ho bontsá bonnete ba sephetho seo ke se fumaneng.

Ke tla hlalosa lintlha tsa bohlokoa sephethong sena e le ho netefatsa hore sephetho se fumanoeng ha sea fetoloa kapa hona ho chitsoa, kapa ho utsuo. Moo likhaello li bileng teng le mathata a bileng teng nakong ea boithuto, li tla kenyeletsoa litlalehong tse tla be li fanoa. Sephetho se fumanoeng se tla sebetsoa ka tsépahalo, se fetoleloe ntle le tsúsumetso ea botho, polotiki kapa libopeho tsa botho. Moithuti o tla ipolela moo ebang o tla be a ena le khohlano malebana le boithuto

Tlaleho ea mofuputsi e tla lokolisa lintlha tsohle tse lumeletsoeng le sekolo sa North West University (Potchefstroom campus), ele ho li lokolisa ka tsela e hlakileng.

Tlhapantsó ea monkakarolo

Ka ho tekena tumellano ena, ‘Na ke tla be ke etsa tumello ea hore ke utloisisa, “me ke batla ho nka karolo boithutong bona):

Ke netefatsa hore boithuto bona ba: **BOINTLLAFATSO TSEBETSONG EA LEKHOTLA LA BAPEPISI METSING MAPAPI LE TAOLO EA BAPEPISI METSENG LESOTHO**

- Ke balile litaba tsohle tse hlalositsoeng tokomaneng ena, ‘me li ngotsoe ka puo eo ke e utloisisang
- Ke ile ka fumana monyetla oa ho botsa lipotso ho beng ba boithuto bona kaofela. Lipotso tsohle tsa ka li arabiloe ka tsela eo ke khotsofetseng.
- Kea utloisisa hore ho nka karolo boithutong bona ke boikhethelo ba ka, ha ke qobelloe ke mang kapa mang.
- Kea utloisisa hore ha ke sa batle ho tsoela pele ka boithuto bona, nka tlohela ntle le ho qobelloa ke mang kapa mang, ‘me nke ke ka khahlapetsoa ha ke sa nka karolo.
- Kea utloisisa hore nka tlohella ka lehare ho nka karolo boithutong bona, e le hobane mofuputsi a hlokometse ho hong molemong oa ka, kapa ha ke sa utloisise se lebeletsoeng.

Tekeno sebakeng sena(Letsatsi) 20.....

.....

.....

Tekeno ka monkakarolo

Tekeno ka paki

Tlhapantsó ea mohlapanstí

‘Na ke hlapanya hore:

- Ke hlalositse litaba tsohle malebana le tokomane ena ho

- Ke ile ka mo khothaletsa ho botsa lipotso, 'me ka ipha nako hore ke mo hlalositse sohle seo a neng a hloka ho se tseba.
- Ke khotsofetse hore o utloisisa lintlha tsohle tsa boithuto bona, joalokaha ke hlalositse ka holimo.
- Ha kea sebelisa toloko.

Tekeno Sebakeng sena..... Letsatsi..... 20....

.....
 (Tekeno ka mohlapantsi) (Tekeno ka paki)

Tlhapantsó ka mofuputsi/mofuputsi ea ikemetseng

I 'Na Ke hlapantsá hore:

- Ke hlalositse lintlha tsohle malebana le boithuto tokomaneng ena).....
- Ke mo khothalelitse ho botsa lipotso, "me ka ipha nako e lekaneng ho araba lipotso kaofela.
- Ke khotsofetse hore o utloisisa lintlha tsohle tsa boithuto bona, joalokaha re buile ka tsona kaholimo
- Ha kea sebelisa toloko.

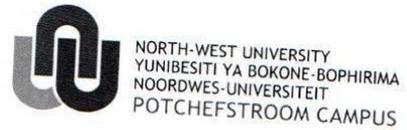
Tekeno sebakeng sena..... (Letsatsi) 20....

.....
 (Tekeno ea mofuputsi) (Tekeno ea paki)

Tekeno sebakeng sena..... (Letsatsi) 20....

.....
 (Tekeno ea mofuputsi ea ikemetseng) (Tekeno ea paki)

ANNEXURE F: Information leaflet and consent form for registered nurses



**PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM
FOR REGISTERED NURSES**

**TITLE OF THE RESEARCH PROJECT: STRENGTHENING REGULATION OF
TRADITIONAL MIDWIFERY PRACTICE IN LESOTHO**

REFERENCE NUMBERS: 24776734

PRINCIPAL INVESTIGATOR: FLAVIA MOETSANA-POKA

ADDRESS: P. O. BOX 9110, MASERU 0100, LESOTHO

CONTACT NUMBER: (+266) 58043999 OR (+266) 63944145

You are being invited to take part in a research project that forms part of my research study which is on "Strengthening regulation of traditional midwifery practice in Lesotho; with the purpose of strengthening traditional midwifery regulatory mechanisms in order to enhance effective regulatory mechanisms to promote patient/client safety. Please take some time to read the information presented here, which will explain the details of this project. Please ask the researcher any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the **Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University (NWU-00176-15-S1)** and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki and the ethical guidelines of the National Health Research Ethics

Committee of the Faculty of Health Sciences of the North-West University (NWU – Potchefstroom campus) and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki and the ethical guidelines of the National Health Research Ethics Council. It might be necessary for the research ethics committee members or relevant authorities to inspect the research records.

What is the research study all about?

This study will be conducted in one of the ten districts in Lesotho and will involve semi-structured interviews with the experienced health researchers trained in conducting interviews, collect data through audio recorder, field notes and transcribed verbatim; then, the researcher will independently analyse the transcribed data and field notes with the use of the analysis guide. The traditional midwives, registered nurses and members of the Lesotho Universal Medicine Men and Herbalist Council will be participants in the study.

The objectives of this research are:

- Explore and describe the perceptions of traditional midwives regarding regulation of their practice.
- Explore and describe the perceptions of members of the Lesotho Universal Medicine men and Herbalists Council regarding regulation of traditional practice.
- Explore and describe the perceptions of registered nurses responsible for supervising traditional midwives regarding regulation of their practice.
- Explore strategies that can be used to regulate traditional midwifery practice.

Why have you been invited to participate?

You are being asked to voluntarily participate in this study because you are a registered nurse working at the health centre where you monitor and supervise the traditional midwifery practice; and your perceptions are very much valuable for this study.

What will your responsibilities be?

If you agree to take part in this study, you will be expected to respond to the interview questions, and you will be involved in the research process throughout the study to ensure trustworthiness.

I would like you to give a written consent at your own will, to take part in my study, but the first step will be to provide you with a detailed verbal and written explanation about the purpose of the study, its significance, benefits and any risks that would result from the study. All this information will be provided in a language that you are comfortable with or prefer most; and you are free to bring along your relatives to understand clearly the information given. You will be allowed to take your time; a day or so, to make your own decision whether you approve to take part in the study or not; and it is your right to agree or disagree without any prejudice at any point in time. When you have made your decision, you will be requested to sign two copies of informed consent; and one copy will be your own copy, the other will be taken by the researcher. Illiterate participants will be requested to sign using their thumbprint or initials that everything was explained to them, and they understand all the information that was explained to them. The independent person will be asked to co-sign with the illiterate participants that the participant understands the information, and willingly made their mark.

You will be expected to get full information about the study prior to signing a voluntary written informed consent as an approval to take part in the study. It will be followed by signing an informed consent after you have had time to make your decision, and having understood and agreeing to take part in the study. You will be expected to participate in the study at your own free will, and if you decide to withdraw from the study, you are free to do so at any time during the research process, without any prejudice.

You will be expected to ensure that the researcher and the transcriber involved in the study have signed a confidentiality agreement before collection of data. You will be requested to avail yourself for the interviews with the researcher which will take 30 - 45 minutes, and you are to warn the researcher if you need to take breaks at any time to avoid being pressurised by the researcher. The interviews will be held at your home or at any place where you will feel comfortable to hold interviews. The researcher will agree with you to use the interview schedule which will be more suitable for you throughout the study.

You will be individually interviewed and asked questions in a language you prefer (either English or Sesotho), and you will be given time to express yourself in the language you are comfortable with when responding to the questions. If you don't understand a question, you are free to ask questions to the researcher; either to repeat the question or clarify the question in the language you are comfortable with or prefer.

You will be expected to ask questions to clarify any misunderstandings on the data collected and analysed to verify whether the themes developed from the interviews are true reflections of the deliberations the researcher had with the participant.

You are to get an honest report from the researcher, on the findings of the study
You will be expected to contact the North West University Ethics Committee (Potchefstroom campus) if there are any concerns regarding the protection and non-exposure to unscientific and unethical processes of the study.

If you agree to take part in this study, you will be expected to respond to the interview questions, and you will be involved in the research process throughout the study to ensure trustworthiness.

I would like you to give a written consent at your own will, to take part in my study, but the first step will be to provide you with a detailed verbal and written explanation about the purpose of the study, its significance, benefits and any risks that would result from the study. All this information will be provided in a language that you are comfortable with or prefer most; and you are free to bring along your relatives to understand clearly the information given.

Will you benefit from taking part in this research?

There are no direct benefits in taking part in this study.

The indirect benefits for you as a participant will be

- *The traditional midwifery roles, responsibilities and expectations will be clarified and well defined.*

- *The supporting legal frameworks will be developed to guide the traditional midwifery practice to ensure that the practice they provide is a safe practice for clients; and this will also reduce several complaints or allegations laid against them regarding unsafe and hazardous traditional practices which would lead to maternal death.*
- *Traditional midwifery practice will be legally protected and more recognized to strengthen the linkages within the health care system, as you provide first line of care in the hard to reach areas.*
- *The study will expand the knowledge base on regulation of traditional midwifery practice as there is limited literature available. Local knowledge on cultural and traditional midwifery practices will be shared with other health care professionals for the benefit of the health care system as a whole, and the public in receiving safe care.*

Are there risks involved in your taking part in this study?

- Low Risk – boredom, time, hunger

What will happen in the unlikely event of some form of discomfort occurring as a direct result of your taking part in this research study?

- You will be given a break whenever you feel tired.
- You will be provided with a snack when you feel hungry. You should feel free to express yourself.
- Should you have the need for further discussions after the study as a result of any discomforts of weather at areas where the interview will be conducted an opportunity will be arranged for you to seek medical help.

Who will have access to the data?

- *Anonymity will be maintained by using the numbers or alphabets as a reference to the participants during the interviews; the names of the participants will not be used and instead a unique number will be assigned to protect the participants' identity.*
- *Confidentiality will be ensured by ensuring that the researcher, transcribe and co-coder who will be accessing the participants' data on audiotapes, transcripts and field notes will sign a confidentiality agreement to keep the participants' data confidential at all times, and throughout the research process. The researcher will keep all the information obtained in the locked cupboards at North-West University (NWU) at Potchefstroom campus for a period of five years, following which; the data will all be destroyed.*
- *Reporting of findings will be anonymous by ensuring that the researcher maintains integrity on the publication of content and present the results by avoiding use of the participants' names and locations of residence during the presentation. The researcher will ensure that any presentation made conforms to acceptable ethical practices, being honest in its content and presentation. Only the researchers transcribe and co-coder will have access to the data as they will first sign a confidentiality agreement before accessing the data. Data will be kept safe and secure by locking electronic and hard copies in locked cupboards in the researcher's office and for electronic data it will be password protected. (As soon*

as data has been transcribed it will be deleted from the recorders.) Data will be stored for five (5) years at North-West University (NWU), at Potchefstroom campus, after which it will be destroyed.

Will you be paid to take part in this study and are there any costs involved?

No, you will not be paid to take part in the study but refreshments will be prepared for you, at the time you will need to take a break. Travel expenses will be paid for those participants who have to travel to the study site. There will thus be no costs involved for you, if you do take part.

Is there anything else that you should know or do?

- You can contact .Mrs. Flavia Moetsana-Poka at (+266) 58043999 or email - fla_mpoka@yahoo.co.uk. If you have any further queries or encounter any problems.
- You can contact the Health Research Ethics Committee via Mrs Carolien van Zyl at (+27) 018 299 2094; carolien.vanzyl@nwu.ac.za if you have any concerns or complaints that have not been adequately addressed by the researcher.
- You will receive a copy of this information and consent form for your own records.

How will you know about the findings?

- The findings of the research will be shared with you by preparing research reports to disseminate the findings through publications, presentations and conferences to you as the participants who took part in the study, your colleagues and the health professionals in order to assess trustworthiness, reliability and validity of the study by ensuring that the strategies and criteria to adhere to ensure rigour are addressed. The four quality criteria include credibility, transferability, dependability and conformability. The presentation of results will be to the level of your understanding.
- I will also explain the ethical points which have to be critically considered in ensuring that data is not manipulated or invented; data is not forged or stolen because I will be violating the value of veracity (truth and truth-telling). Limitations and problems encountered during the research process will be included in the report, and not concealed or ignored. Data will be honestly analysed and, interpreted without personal, political and emotional bias; and the researcher will also maintain integrity in the presentation. The researcher will declare any conflict of interest and identify and funding received for the study.

The researcher's presentation will be clear and logical addressing the following sections below. The researcher will highlight how trustworthiness was addressed, and also identify the specific criteria used to ensure reliability and validity of a qualitative research study:

Declaration by participant

By signing below, I agree to take part in a research study entitled: Strategies to strengthening regulation of traditional midwifery practice in Lesotho

I declare that:

- I have read this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions to both the person obtaining consent, as well as the researcher and all my questions have been adequately answered.
- I understand that taking part in this study is voluntary and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) on (*date*) 20....

.....
Signature of participant

.....
Signature of witness

Declaration by person obtaining consent

I (*name*) declare that:

- I explained the information in this document to
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter.

Signed at (*place*) on (*date*) 20....

.....
Signature of person obtaining consent

.....
Signature of witness

Declaration by researcher

I (*name*) declare that:

- I explained the information in this document to

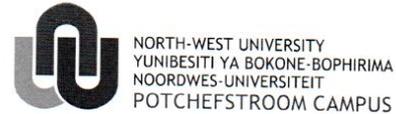
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter.

Signed at (*place*) on (*date*) 20....

.....
Signature of researcher

.....
Signature of witness

**Annexure G: Information leaflet and consent form for Lesotho Universal
Medicine Men and Herbalist Council Members**



**PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM
FOR LESOTHO UNIVERSAL MEDICINE MEN AND HERBALIST
COUNCIL MEMBERS**

**TITLE OF THE RESEARCH PROJECT: STRENGTHENING REGULATION OF
TRADITIONAL MIDWIFERY PRACTICE IN LESOTHO**

REFERENCE NUMBERS: 24776734

PRINCIPAL INVESTIGATOR: FLAVIA MOETSANA-POKA

ADDRESS: P. O. BOX 9110, MASERU 0100, LESOTHO

CONTACT NUMBER: +266 58043999 OR +266 63944145

You are being invited to take part in a research project that forms part of my study on "Strengthening regulation of traditional midwifery practice in Lesotho," with the aim of strengthening traditional midwifery regulation in order to enhance effective regulatory mechanisms promoting safe practice. Please take some time to read the information presented here, which will explain the details of this project. Please ask the researcher any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the **Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University (NWU-00176-15-S1)** and will be conducted according to the ethical guidelines and principles of the international

Declaration of Helsinki and the ethical guidelines of the National Health Research Ethics Council. It might be necessary for the research ethics committee members or relevant authorities to inspect the research records.

What is the research study all about?

This study will be conducted in one of the ten districts in Lesotho and will involve semi-structured interviews with the experienced health researchers trained in conducting interviews, collect data through audio recorder, field notes and transcribed verbatim; then, the researcher will independently analyse the transcribed data and field notes with the use of the analysis guide. The traditional midwives, registered nurses and members of the Lesotho Universal Medicine Men and Herbalist Council will be participants in the study.

The objectives of this research are:

- Explore and describe the perceptions of traditional midwives regarding regulation of their practice.
- Explore and describe the perceptions of members of the Lesotho Universal Medicine men and Herbalists Council regarding regulation of traditional practice.
- Explore and describe the perceptions of registered nurses responsible for supervising traditional midwives regarding regulation of their practice.
- Explore strategies that can be used to regulate traditional midwifery practice.

Why have you been invited to participate?

- You have been invited to participate because you are a mature woman, culturally accepted and respected by your community, more experienced and up to date with knowledge and skills in providing traditional midwifery care, and your perceptions are very valuable to us (researchers).

What will your responsibilities be?

If you agree to take part in this study, you will be expected to respond to the interview questions, and you will be involved in the research process throughout the study to ensure trustworthiness.

I would like you to give a written consent at your own will, to take part in my study, but the first step will be to provide you with a detailed verbal and written explanation about the purpose of the study, its significance, benefits and any risks that would result from the study. All this information will be provided in a language that you are comfortable with or prefer most; and you are free to bring along your relatives to understand clearly the information given. You will be allowed to take your time; a day or so, to make your own decision whether you approve to take part in the study or not; and it is your right to agree or disagree without any prejudice at any point in time. When you have made your decision, you will be requested to sign two copies of informed consent; and one copy will be your own copy, the other will be taken by the researcher. Illiterate participants will be requested to sign using their thumbprint or initials that everything was explained to them, and they understand all the information that was explained to them. The independent person will be asked to co-sign with the illiterate participants that the participant understands the information, and willingly made their mark.

You will be expected to get full information about the study prior to signing a voluntary written informed consent as an approval to take part in the study. It will be followed by signing an informed consent after you have had time to make your decision, and having understood and agreeing to take part in the study. You will be expected to participate in the study at your own free will, and if you decide to withdraw from the study, you are free to do so at any time during the research process, without any prejudice.

You will be expected to ensure that the researcher and the transcribe involved in the study have signed a confidentiality agreement before collection of data. You will be requested to avail yourself for the interviews with the researcher which will take 30 - 45 minutes, and you are to warn the researcher if you need to take breaks at any time to avoid being pressurised by the researcher. The interviews will be held at your home or at any place where you will feel comfortable to hold interviews. The researcher will agree with you to use the interview schedule which will be more suitable for you throughout the study.

You will be individually interviewed and asked questions in a language you prefer (either English or Sesotho), and you will be given time to express yourself in the language you are comfortable with when responding to the questions. If you don't understand a question, you are free to ask questions to the researcher; either to repeat the question or clarify the question in the language you are comfortable with or prefer.

You will be expected to ask questions to clarify any misunderstandings on the data collected and analysed to verify whether the themes developed from the interviews are true reflections of the deliberations the researcher had with the participant.

You are to get an honest report from the researcher, on the findings of the study
You will be expected to contact the North West University Ethics Committee if there are any concerns regarding the protection and non-exposure to unscientific and unethical processes of the study.

Will you benefit from taking part in this research?

The study will influence the development of guidelines and minimum standards to outline the legal responsibilities and expectations of the traditional midwives in the event of breach of instructions, maltreatment, or mishap; and to enforce compliance with the aim of protecting the public against unsafe and hazardous traditional practices.

There are no direct benefits.

The Indirect benefits for you as a participant will be

- Your roles, responsibilities and expectations as a traditional midwife will be clarified and well defined.
- Your traditional midwifery practice will be legally protected and more recognized to strengthen the linkages within the health care system, as you provide first line of care in the hard to reach areas.
- The study will expand the knowledge base on regulation of traditional midwifery practice as there is limited literature available. Local knowledge on cultural and traditional midwifery practices will be shared with other health care professionals

for the benefit of the health care system as a whole, and the public in receiving safe care.

Are there risks involved in your taking part in this study?

- Low Risk – boredom, time, hunger

What will happen in the unlikely event of some form of discomfort occurring as a direct result of your taking part in this research study?

- You will be given a break whenever you feel tired.
- You will be provided with a snack when you feel hungry. You should feel free to express yourself.
- Should you have the need for further discussions after the study as a result of any discomforts of weather at areas where the interview will be conducted an opportunity will be arranged for you to seek medical help.

Who will have access to the data?

- Anonymity will be maintained by using the numbers or alphabets as a reference to the participants during the interviews; the names of the participants will not be used and instead a unique number will be assigned to protect the participants' identity.
- Confidentiality will be ensured by ensuring that the researcher, transcribe and the co-coder who will be accessing the participants' data on audiotapes, transcripts and field notes will sign a confidentiality agreement to keep the participants' data confidential at all times, and throughout the research process. The researcher will keep all the information obtained in the locked cupboards at North West University for a period of five years, following which; the data will all be destroyed.
- Reporting of findings will be anonymous by ensuring that the researcher maintains integrity on the publication of content and present the results by avoiding use of the participants' names and locations of residence during the presentation. The researcher will ensure that any presentation made conforms to acceptable ethical practices, being honest in its content and presentation. Only the researchers and the transcribers will have access to the data as they will first sign a confidentiality agreement before accessing the data.
- Data will be kept safe and secure by locking hard copies in locked cupboards in the researcher's office and for electronic data it will be password protected. (As soon as data has been transcribed it will be deleted from the recorders.) Data will be stored for five (5) years at North West University, after which it will be destroyed.

Will you be paid to take part in this study and are there any costs involved?

No, you will not be paid to take part in the study but refreshments will be prepared for you, at the time you will need to take a break. Travel expenses will be paid for those participants who have to travel to the study site. There will thus be no costs involved for you, if you do take part.

Is there anything else that you should know or do?

- You can contact .Mrs. Flavia Moetsana-Poka at (+266) 58043999 or email - fla_mpoka@yahoo.co.uk. If you have any further queries or encounter any problems.
- You can contact the Health Research Ethics Committee via Mrs Carolien van Zyl at (+27) 018 299 2094; carolien.vanzyl@nwu.ac.za if you have any concerns or complaints that have not been adequately addressed by the researcher.

You will receive a copy of this information and consent form for your own records.

How will you know about the findings?

- The findings of the research will be shared with you by preparing research reports to disseminate the findings through publications, presentations and conferences to you as the participants who took part in the study, your colleagues and the health professionals in order to assess trustworthiness, reliability and validity of the study by ensuring that the strategies and criteria to adhere to in order to ensure rigour are addressed. The four quality criteria include credibility, transferability, dependability and conformability. The presentation of results will be to the level of your understanding.
- I will also explain the ethical points which have to be critically considered in ensuring that data is not manipulated or invented; data is not forged or stolen because I will be violating the value of veracity (truth and truth-telling). Limitations and problems encountered during the research process will be included in the report, and not concealed or ignored. Data will be honestly analysed and, interpreted without personal, political and emotional bias; and the researcher will also maintain integrity in the presentation. The researcher will declare any conflict of interest and identify any funding received for the study.
- The researcher's presentation will be clear and logical addressing the following sections below. The researcher will highlight how trustworthiness was addressed, and also identify the specific criteria used to ensure reliability and validity of a qualitative research study:

Declaration by participant

By signing below, I agree to take part in a research study entitled "Strategies to strengthening regulation of traditional midwifery practice in Lesotho"

I declare that:

- I have read this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions to both the person obtaining consent, as well as the researcher and all my questions have been adequately answered.

- I understand that taking part in this study is voluntary and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*)..... on (*date*) 20....

.....
 Signature of participant Signature of witness

Declaration by person obtaining consent

I (*name*) declare that I explained the information in this document to

- I encouraged him/her to ask questions and took adequate time to answer them
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above.
- I did not use an interpreter.
- Signed at (*place*)..... on (*date*) (Letsatsi)..... 20....

.....
 Signature of person obtaining consent Signature of witness

Declaration by researcher

I (*name*) declare that I explained the information in this document to).....

- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above.
- I did not use an interpreter.

Signed at (*place*)..... on (*date*) 20....

.....
 Signature of researcher Signature of witness

ANNEXURE H: Confidentiality undertaking



NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT

CONFIDENTIALITY UNDERTAKING

entered into between:

I, the undersigned

Prof / Dr / Mr / Ms _____

Identity Number: _____

Address: _____

Hereby undertake in favor of the **NORTH-WEST UNIVERSITY**, a public higher education institution established in terms of the Higher Education Act No. 101 of 1997

Address: Office of the Institutional Registrar, Building C1, 53 Borchard Street, Potchefstroom, 2522

(hereinafter the "NWU")

1 Interpretation and definitions

1.1 In this undertaking, unless inconsistent with, or otherwise indicated by the context:

1.1.1 "Confidential Information" shall include all information that is confidential in its nature or marked as confidential and shall include any existing and new information obtained after the Commencement Date, including but not be limited in its interpretation to, research data, information concerning research participants, all secret knowledge, technical information and specifications, manufacturing techniques, designs, diagrams, instruction manuals, blueprints, electronic artwork, samples, devices, demonstrations, formulae, know-how, intellectual property, information concerning materials, marketing and business information generally, financial information that may include remuneration detail, pay slips, information relating to human capital and employment contract, employment conditions, ledgers, income and expenditures and other materials of whatever description in which the NWU has an interest in being kept confidential;

1.1.2 "Commencement Date" means the date of signature of this undertaking; and

1.2 The headings of clauses are intended for convenience only and shall not affect the interpretation of this undertaking.

2 Preamble

2.1 In performing certain duties requested by the NWU, I will have access to certain Confidential Information provided by the NWU in order to perform the said duties and I agree that it must be kept confidential.

2.2 The NWU has agreed to disclose certain of this Confidential Information and other information to me subject to me agreeing to the terms of confidentiality set out herein.

3 Title to the Confidential Information

I hereby acknowledge that all right, title and interest in and to the Confidential Information vests in the NWU and that I will have no claim of any nature in and to the Confidential Information.

4 Period of confidentiality

The provisions of this undertaking shall begin on the Commencement Date and remain in force indefinitely.

5 Non-disclosure and undertakings

I undertake:

5.1 to maintain the confidentiality of any Confidential Information to which I shall be allowed access by the NWU, whether before or after the Commencement Date of this undertaking. I will not divulge or permit to be divulged to any person any aspect of such Confidential Information otherwise than may be allowed in terms of this undertaking;

5.2 to take all such steps as may be necessary to prevent the Confidential Information falling into the hands of an unauthorized third party;

5.3 not to make use of any of the Confidential Information in the development, manufacture, marketing and/or sale of any goods;

5.4 not to use any research data for publication purposes;

5.5 not to use or disclose or attempt to use or disclose the Confidential Information for any purpose other than performing research purposes only and includes questionnaires, interviews with participants, data gathering, data analysis and personal information of participants/research subjects;

5.6 not to use or attempt to use the Confidential Information in any manner which will cause or be likely to cause injury or loss to a research participant or the NWU; and

5.7 that all documentation furnished to the Covenanter by the NWU pursuant to this undertaking will remain the property of the NWU and upon the request of the NWU will be returned to the NWU. I shall not make copies of any such documentation without the prior written consent of the NWU.

6 Exception

The above undertakings by myself shall not apply to information which I am compelled to disclose in terms of a court order.

7 Jurisdiction

This undertaking shall be governed by South African law be subject to the jurisdiction of South African courts in respect of any dispute flowing from this undertaking.

8 Whole agreement

8.1 This document constitutes the whole of this undertaking to the exclusion of all else.

8.2 No amendment, alteration, addition, variation or consensual cancellation of this undertaking will be valid unless in writing and signed by me and the NWU.

Dated at Potchefstroom this _____ 20____

Witnesses:

1

2

(Signatures of witnesses)

.....

(Signature)

ANNEXURE I Transcription of an interview with a traditional midwife

Participant no. 12 (tm12)

Facilitator:

1. Can you please tell us your experiences regarding the Lesotho Universal Medicine Men and Herbalist Council's current systems regarding regulation of traditional midwifery practice in Lesotho?

NO. 12

I have not heard about that Council and as traditional midwives, we are not involved with the Council.

Facilitator:

2. Can you tell us your perceptions on the roles of the Lesotho Universal Medicine Men and Herbalist Council towards patient safety when providing traditional midwifery services?

NO. 12

The Council should take responsibility to visit the traditional midwives within our area to have meetings with them, in order to establish how we can work together to assist each other. There is need to also assist each other with the provision of herbs. If we are allowed to practice by the Ministry of Health, we would like to be part of the Council so that we can work together, share our knowledge and experiences together.

Facilitator:

3. What actions are taken by the Lesotho Medicine Men and Herbalist Council in case where there has been any kind of mismanagement or putting a patient's life at risk during provision of traditional midwifery care?

NO. 12

Those in higher authority or the Council would investigate what happened, and then make the decision who is to blame between the traditional midwife and the pregnant woman, so that proper action can be taken.

Facilitator:

What actions can be taken when it has been established that the traditional midwife is responsible for what happened?

NO. 12

We have the chiefs and counsellors to take action; and it depends whether those practices have been allowed by the Ministry of Health or not. If we are not allowed, I will be sued by the laws of the country. I can be disciplined on the basis of the evidence established, and the Council would be given responsibility to exercise their mandate if allowed to register and authorise traditional midwives to practice.

Facilitator:

4. How can regulation help improve traditional midwifery practice in order to promote safe care?

NO. 12

If we are allowed to practice as traditional midwives, we would like to be provided with equipment (e.g. scissors, gloves etc). We also would recommend trainings from the health centre nurses to improve their skills in order to provide safe care. To also work together with the nurses at the health facilities in the case that if the traditional midwife has assisted a pregnant woman in an emergency and comes across any complications, she can call the nurse at the health facility for help. The laws and regulations should be developed to guide our practice, and we should be licensed to practice in order to control our practice.

ANNEXURE J Transcription of an interview with a registered nurse

Participant NO. 8 (RN8)

Facilitator:

1. *Can you tell us about your perceptions regarding regulation of traditional midwifery practice in instances where there are reported malpractices from the community?*

NO. 8

My perception is that the traditional midwives should stop conducting home deliveries because of high prevalence of HIV. You will find that mothers who delivered at home yet they know their HIV status, their children are born HIV positive. Proper measures will have not been taken to prevent infecting the new-born. The traditional midwives also get infected because they assist women using their bare hands because there are no gloves. Both the mother and the traditional midwife get exposed to infection. The pregnant women also do not disclose their HIV status to the traditional midwives assisting them. The traditional midwives do not know what measures to take in order to protect the child from exposure of HIV infections. After the child is born, the new-born does not get the medications it is supposed to get on time. Also, the traditional midwives are not able to manage bleeding in case there is a woman who loses a lot of blood.

Facilitator:

So you mean stopping home deliveries will be for the benefit of the mother, new-borns and the traditional midwives?

NO. 8

Yes.

Facilitator:

2. *Are there any legal actions taken against a traditional midwife with a reported malpractice? If, yes, what kind of actions are taken, and by who?*

No. 8

At our health centre, no legal action has been taken at any time, but home deliveries are still done. I remember there are incidences where the chief conducts deliveries herself, and you wonder how we can take action against a person like her who is in authority.

Hmmm!!!!

You don't even know whether to report her to the police or do what. We are still not sure of the procedure that has to be followed to report those incidences; whether to the police or the chief.

Facilitator:

You mean that the chief is also involved in conducting home deliveries?

NO. 8

Yes the chief is also involved. So we do not know where to report these incidences when they do occur. And we often inform the community members that home deliveries are not allowed. All pregnant women have to come to the health centre; but they still continue anyway.

Facilitator:

So you mean you need a protocol which clearly states the reporting procedure to be followed when traditional midwives or anybody continues to conduct home deliveries.

NO. 8

Yes. There is need for that protocol to guide us on what should be done to report such incidences of home deliveries. We need to know who we have to report to.

Facilitator:

Does that mean that there is nowhere you report these home deliveries. Either DHMT or anywhere?

NO. 8

I don't know whether reports have ever been made to DHMT.

Hmmm!!!!

These people usually hide the people who assisted them. Some would report that they were assisted by their mother. Some say they delivered on their own when they come to the health centre. What I know is that we usually threaten them that we will report them to the police, but no action is taken.

Facilitator:

3. What are the responsibilities of the traditional midwives towards safe patient care?

NO. 8

They follow up on the sick clients, e.g. TB patients, Patients on ARV's, pregnant and breast feeding women etc., to ensure that they take their medication as required; attend clinics on the set dates to avoid relapse; weigh children and encourage the sick to go to the health centres.

Facilitator:

4. What do you think are the strategies/approaches that can be taken to strengthen regulation of traditional midwifery practice?

NO. 8

The women who deliver at home should be sued together with the traditional midwives who assisted them.

Facilitator:

Who should sue these people?

NO. 8

It is the responsibility of the chief. If the chief fails to do so, the matter should be reported to the police. There should be an established committee composed of the chief, the counsellors and village elders who will take responsibility to reprimand the traditional midwives who are reported to be continuing to conduct home deliveries.

Hmmmm!!!

Parliament should establish the law that restricts home deliveries, and serious action should be taken against those people who contravene this law. The traditional midwives should be registered under their own council which will regulate them and act accordingly when such incidences do occur.

Facilitator:

What can be done to reach out on people who live in the hard to reach areas?

NO. 8

The pregnant women should come nearer the health centres to stay at the shelters, and should be provided with food. Even though they usually complain about the food they eat.

ANNEXURE K

Transcription of an interview conducted with a LUMMHC member

(partly translated in English and Sesotho)

Participant no 5 (PC5)

Facilitator

1. Can you please tell us about your role regarding regulation of traditional midwifery practice, and any legal mechanisms you have in place?

Participant 5

“Hmmm!!! U oa tseba, ha re laole bapepisi metseng, empa re le lingaka tsa sets, re nka karolo ho hlokomela mosali oa mokhachane mane hae hobane re ba fa lipitsa nakong ea bokhachane. Re fana hape ka meriana ea Sesotho ho bona bapepisi metsing.”

The traditional healers are registered and licensed as such. They should be known by the chief of the village where they originate, and also to the office of the Council. We protect the use of the traditional healers and ensure that we protect our tradition and culture.

Facilitator

Does it mean that you do not work together with the traditional midwives, unless only when the pregnant women consult you traditional healers?

Participant 5

“U oa tseba ha re sebetse mmoho le batho bao. Re bile le liphutheho tse ngata tseo re neng re batla ho sebetsa mmoho le baoki ba litsing tsa bophelo metseng, empa ha re so khone ho lumellana hore re sebetse mmoho. Re ne re utloa ho hlokahala hore re le lingaka tsa setso, re kopane le lekala la bophelo, ele hona ho otlolla meralo ea tsébetso, le hore re arolelane litsebo tsa rona. Sechaba sea tla haolo ho rona, hammoho le bona bakhachane.

Facilitator

What does the person get when registered and licensed?

Participant 5

Yes we do register and license all the traditional healers in Lesotho, and we issue them with the certificates. It is not allowed to practice without a license and registration. “Ehlile ke tolo ea molao ho etsa joalo, mme ha hoa lumelleha hore ngaka ea setso a sebetse feela ntle le certificate, ebile hape certificate seno ke sona seo a se sebelisang ho batla meriana ea setso.

Facilitator

Is there any action taken on those that practice without a license?

Participant 5

Yes we do take action, starting from the village. A person who is not licensed is not allowed to obtain any traditional herbs from the land in our villages. If found digging such herbs, that person is asked to produce a license; and if he/she does not have it, he is sued as per the laws of obtaining the Traditional herbs.

Hmmmm!!!

The traditional healers are required to report themselves to the office of the traditional Council. Our role then is to investigate all of the traditional healers to verify that they have been trained as traditional healers, who trained them and who authorised them to practice. Hmmmm!!!! That is where the chiefs will also be required to provide proof that they do know about the traditional healers within their villages, they should know the services they provide to the community as we have different categories of traditional healers. Then the Council registers all the practitioners after verifying their status.

Facilitator

Are there other Traditional Councils besides this one?

Participant 5

No I do not know any other Council except this one. “Ha ke e tsebe kannete.” Our Council is the one that registers all the traditional healers in Lesotho, and we have the

Constitution which gives the traditional healers a mandate to practice as such; and the Constitution was enacted in 1978.

Facilitator

2. What action is taken in situations when any kind of traditional midwifery malpractice has been reported?

Participant 5

Our office has not received any kind of those reports.

Facilitator

Does your Constitution have any clause which talks about the traditional midwifery practices and any action that should be taken in case they are involved in any kinds of malpractices that put the lives of the community at risk?

Participant 5

“Ee, ho joalo. Aku re ke e quote, “traditional council protects and safeguard the care provided by the traditional healers.” Hmmm!!! I believe if the traditional midwives are involved in any kind of malpractices, we have a responsibility to take action as per our Constitution.

Facilitator

Does the Constitution clearly spell out what has to be done in case there is a reported malpractice of traditional midwives?

Participant 5

No, it does not specify the traditional midwives; but it generally talks about protecting and safeguarding the public on the provision of care. But if the care provided to the public is compromised, we feel we do have the responsibility, and those incidences have to be reported to the chief of the village.

Facilitator

Does the Council register the traditional midwives?

Participant 5

No it does not.

Facilitator

3. What do you think are the strategies/approaches that can be used to strengthen regulation of traditional midwifery practice by ensuring that patient safety is met at all times, and proper action is taken against those with reported malpractices?

Participant 5

The Ministry of Health should open doors for us, because right now we do not work together. We feel that we are being neglected, and who suffers? It is the public themselves.

Hmmmm!!!

If the Ministry of Health would assist with training of the traditional midwives to ensure that they provide safe care together. We should not avoid the fact there are contributions that we make to the communities because some clinics are very far to reach, and some people could lose their lives while travelling to the health centres. We are there as traditional healers and the traditional midwives, saving people's lives in the communities, therefore we need to be given more recognition for us to work together with the Ministry of Health.

Hmmmmmm!!!! As traditional healers, we need to incorporate the traditional midwives into our Council so that we regulate them. This will be for the benefit of the public good health and safety. Within the villages, there should be nurses and the traditional healers who are taking care of the sick in our communities, therefore we need each other.

We need to work together with the Ministry of Health. As traditional healers, we need to advice or refer the clients to go to the health centres if they have conditions that we are not able to manage. The same way, they should also refer their clients to us.

There is need to review our law so that we can then make amendments to the law to incorporate them.

Annexure L Declaration by Language editor

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CONFIRMATION LETTER: EDITING OF A DOCUMENT

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21 November 2016	I hereby certify that I have edited the following master's dissertation: STRENGTHENING REGULATION OF TRADITIONAL MIDWIFERY PRACTICE IN LESOTHO written by Ms F.M. Moetsana-Poka
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Thank you



Prof VJ Ehlers