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The uptake of skilled birth attendants' services in rural Nepal: A qualitative study

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Abstract

Aim and objective: The general aim of this research was to explore why women do or do not want to uptake Skilled Birth Attendants' (SBAs) services during childbirth. The objective was to explore the factors affecting the uptake of SBAs' services during childbirth in rural Nepal.

Methods: Semi-structured interviews were conducted. The data were analysed using thematic analysis.

Setting: The fieldwork was conducted in a rural area, in a western hill district of Nepal.

Participants: Interviews were conducted with 24 married women aged 18-49, who had given birth during the three years prior to the time of interview. Sixteen women were SBA users and eight were non-SBA users. Eight relatives, such as husbands, and parents-in-law were also interviewed as key informants.

Findings: Four themes were identified as affecting the uptake of skilled care during childbirth: (1) Women's individual characteristics; (2) Choice of, and access to, SBA services; (3) Cultural practice, gender role and decision making; and (4) Attitude and quality of SBAs and the hospital environment.

Conclusion: A wide range of factors affect the uptake of SBAs services. These include: lack of SBAs in rural areas; women's autonomy; difficult terrain; widespread poverty and illiteracy; limited resources and traditional and cultural attitudes; and gender factors. However, to date, women's experiences and preferences have been overlooked in service design and development. There is a need for specific maternity service development, based on women's experiences and perceptions. The establishment of a fully trained cadre of

midwives, operating according to a professional code of ethics, could improve the quality of care in the existing health care facilities.

Keywords: *Skilled birth attendants, Nepal, South Asia*.

Background

In the late 1990s, the Millennium Development Goal (MDG) 5 included two indicators for monitoring progress towards reduction in maternal mortality. The goal was to reduce the maternal mortality ratio (MMR) by three quarters between 1999-2015, and increase the proportion of deliveries carried out with the assistance of skilled health personnel.[1] Including the latter was important because complications during pregnancy and childbirth are a leading cause of death and disability in women in Low-Income Countries (LICs).[2]

Koblinsky and colleagues found that the presence of Skilled Birth Attendants (SBAs) during pregnancy and childbirth significantly reduced maternal morbidity and mortality.[4] An SBA is an accredited health professional and includes midwives, nurses, and doctors, or nurses who have been trained in managing normal (uncomplicated) pregnancies, childbirth, and the immediate postnatal period, as well as the identification, management, and referral of complications in women and newborns.[3] The United Nations has noted that in many low-income countries the levels of maternal morbidity and mortality have declined during the last decade due to improvement in awareness, education, and access to health services.[2]

However, complications during pregnancy and childbirth remain one of the major public health problems and 99% of pregnancy associated deaths occur in LICs.[1] A recent estimate suggests that 289,000 maternal deaths worldwide occur every year, and most of these could be prevented with the availability of SBAs.[5,6] Increasing the proportion of births attended by a skilled person is one of the important indicators in the reduction of maternal mortality, as declared by MDG 5, but the availability of SBAs is low in many developing countries, including Nepal.[5] Importantly, there are proportionally fewer SBAs in the LICs, where significant numbers of women give birth without the help of SBAs.[1]

The most recent MMR in Nepal is 170/100,000 live births.[2] This shows a significant reduction in MMR, from 281/100,000 during the 2006 to 2011 period; although, globally, it is still one of the higher MMRs.[2, 7] This could be because of increase in literacy rate, reduction in poverty, and a decrease in the gender gap, all of which have impacted the shaping of SBA uptake in Nepal. Although the use of SBAs has increased almost threefold, from 13% in 2001 to 36% in 2010, three quarters of births still take place at home, many

without the presence of an SBA.[9] However, under-utilisation of SBA services is one of the factors among many contributing to high MMRs in Nepal.

In the last decade, the reduction in maternal mortality in Nepal has been attributed to a number of factors, including: a decline in the total fertility rate, increased age of marriage, legalisation of abortion, increase in the use of family planning methods, improved antenatal and postnatal care, and immunisation and awareness programmes.[8] Due to an increase in the educational level, more women are more likely to be able to discuss the importance of contraception with their partners or family members. Moreover, girls spend more years in school, which impacts their lives in many ways, including raising their awareness about women's reproductive rights, thereby increasing the likelihood of being able to make decisions about their own health.[2] We would like to add here that underlying socio-economic factors, such as the increasing number of young women in education, and the high proportion of men working abroad, have also contributed to the decline in MMR. However, major challenges still remain in reducing both maternal morbidity and mortality. Currently, in Nepal, one woman dies due to pregnancy-related causes every four hours.[10]

Transportation, distance, and road links to health facilities; geographical barriers; poor communication systems; inadequate numbers of SBAs; and lack of female maternity staff can all affect the uptake of SBAs' services.[9,11-14] The service delivery system and the lack of SBAs in rural areas; the poor physical infrastructure of the health facilities and lack of privacy, as well as women's socio-economic status; the lack of decision-making power and autonomy; and gender and cultural practices are further affecting SBA services uptake, as does the fact that midwifery is not recognised as an independent profession in Nepal.[8, 15-19, 21] The general aim of this study was to explore women's experiences and perceptions about why they want to or do not want to uptake SBA services during childbirth.

Methods

To explore women's experience and perceptions regarding SBA service uptake, this qualitative study comprised semi-structured in-depth interviews[23], with (a) women who had recently given birth with a SBA services; (b) recent mothers who did not used a SBA; and (c) relatives involved in decision-making around maternity care, to explore factors affecting the uptake of SBA at the time of childbirth in rural Nepal.

Setting

The fieldwork was conducted in a rural area, west of the capital, Kathmandu. The study site was a Village Development Committee (VDC) in one of the 16 districts of the Western Development Region of Nepal. The VDC is the smallest unit of local government.[20] In terms of primary health services, this district has Maternal and Child Health Clinics (MCHC), Health Posts (HP), and Sub-Health Posts (SHP).

Participants

Mothers aged 18-49 years, who had given birth during the past three years, were invited to take part. The reason for choosing a three-year period was to capture women's recollections of obstetric events and their labour and births while the events were still fresh and relevant to the local situation in maternity care.[22] Eight relatives (e.g. husbands, mothers-in-law, and one father-in-law), who were involved in decisions about the birthing process, were also interviewed. Snowball sampling was used to identify participants.[23] Initially one female community health volunteer (FCHV) in the research village was asked to identify women in the local community who had recently had a baby. Then the women were asked to identify other possible participants who had recently given birth. If the last birth was more than three years ago, the women were not included in the study.

Data collection and analysis

The data were collected over a four-month period, in 2011, using an interview guideline in Nepali, by the first author and a female interviewer (both native Nepali speakers).[24]All interviews were digitally recorded and lasted from 30 to 45 minutes.[25] Three-day training was provided to a female interviewer by the first author.

Considering the cultural sensitivity, a female interviewer interviewed the women. Pilot interviews were conducted with three women from the study village by the first author and the female interviewer.[26] These interviews identified gaps in, for example, the way of asking a particular question, specific wording, or sitting arrangements.

Data analysis

The first author listened to the recorded interviews several times in order to familiarise himself with words used by the participants. They were first transcribed verbatim in Nepali and then translated into English.[27] Three transcripts were 'back translated' into Nepali by an outsider to ensure the accuracy of the translation.[28]Any issues that were unclear or ambiguous were discussed with the co-authors and resolved.[29] Thematic analysis identified

patterns, categories and themes.[30] A series of discussion were also held with all the co-authors to verify the categories and themes.

Ethical approval

Ethical approval was obtained from the London Metropolitan University and the Nepal Health Research Council. Interviewees were informed that information would be kept secure and that they could withdraw from the interview at any time, and that their responses would remain anonymous.[24]

Findings

Altogether 24 married women who had given birth during the last three years, at the time of the interview, were included. Five mothers-in-law, two husbands and a father-in-law were also interviewed as key informants (Table 1). All were married; as it is rare to encounter an unmarried woman with children in Nepal. Relatively early marriage is the norm.

Table 1: Socio-demographic characteristics of the participants (n=24)

Variables	SBA users (n=16)	SBA non-users (n=8)
Age (in years)		
18-24	10	3
25-34	5	5
35+	1	-
Caste		
Upper caste	10	6
Lower caste	6	2
Family living arrangements		
Extended	11	5
Single	5	3
Women's highest education level		
1-5 years	5	2
6-10 years	7	4
SLC+	3	2
Illiterates	1	-
Place of birth		
Hospital	16	0
Home	-	8
Number of births		
1	8	2
2	4	5
3	4	1

Table 2: Socio-demographic characteristics of men (n=3)

Men's education	Literate (Husbands)	2
	Illiterate (Father-in-law)	1
Age	Less than 40 yrs (Husbands)	2
	More than 40 yrs (Father-in-law)	1
Socio-demographic characteristics of mothers-in-law (n=5)		
Mothers-in-law's education	Literate	1
	Illiterate	4
Age	Less than 60	2
	More than 60	3

The thematic analysis of the transcribed data identified four main themes affecting the uptake of skilled care: (a) women's individual characteristics; (b) choice and access to services; (c) culture, gender, and decision making; and (d) attitude and quality of SBA and the hospital environment.

a) Women's individual characteristics

Younger women and those who had given birth to one or two children were more likely to use SBA services than those who had more than three children and/or were 30 years of age and over. One of the first-time mothers said:

> ''....It was my first delivery. I was too young to give birth at the age of 18. I know it was not an ideal age for delivery so I asked my husband to take me to the hospital for delivery'' (SBA user woman 1).

Women with positive previous birth experiences, such as having had a shorter labour, feeling less pain, and having no complications during the last birth, were less likely to use SBA services. They assumed that their next birth would be similar, for example, this woman said:

> ''....There was no problem and a very short labour for the first birth so I did not have any difficulty delivering at home. I thought this time would be the same but it was more painful and a longer labour than the first one'' (Non-SBA user woman 6).

Women who had faced some pregnancy-related complications during their last pregnancy were more likely to use SBA services. A woman with complications in her last pregnancy described:

> ‘‘...I had one miscarriage before this birth. I had seven or eight antenatal check-ups altogether before I delivered the baby in the hospital’’ (SBA user woman 16).

Women with less education and those who had left school early were less likely to be SBA service users. Most of the interviewees thought that educated mothers were more likely to use SBA. One non-SBA service user stated:

> ‘‘....Girls are less educated and spend fewer years in school than the boys. When the daughter menstruates for the first time parents are more worried about getting her married rather than sending her to school’’ (Non-SBA user woman 1).

Women interviewed reported that their main employment was unpaid housework and agriculture. Some women who had a paid job appeared to be more likely to use SBA services, for example:

> ‘‘....I had a paid job during pregnancy. I earned Nepali Rupees (NRs) 150-200 a day. I didn’t depend on anyone for money to go to the hospital for pregnancy check-ups’’ (SBA user woman 4).

Conversely, one woman who was not involved in paid employment stated:

> ‘‘....I had to ask for money from family members to go to the hospital for antenatal check-ups. I did not like that because I had to justify everything to them when asking for money’’ (Non-SBA user woman 6).

Almost all thought that higher caste women made more use of SBA services, as one woman explained:

‘‘....lower caste women have a higher rate of home delivery, without the help of skilled health professionals, in this area because they are poor and uneducated’’ (SBA user woman 2).

b) Choice and access to SBAs

Rural women in remote villages faced numerous problems in accessing appropriate maternity care. Lack of public transport services and poor rural roads made using SBA services difficult. A woman complained:

> ‘‘The road condition was so poor. It was more difficult and painful to travel by bus on this poor road. Bumpy roads create a lot of jerks during travel, so it was easier to walk rather than to go by bus’’ (SBA user woman 11).

Another woman described her reasons for non-use of SBA services:

> ‘‘Men carried me in a Jhulungo (a traditional stretcher made from wood and blankets).The hospital is too far to go. It takes nearly 3-4 hours to reach so I decided to deliver at home this time’’ (Non-SBA user woman 7).

Poor infrastructure in the health facility (e.g. lack of beds for labour and after delivering the baby, poor sanitation/hygiene including poor waste disposals, noise or lack of light and long-waiting times) make women less likely to use the services of SBAs. A woman reported:

> ....The labour and delivery room of the hospital was dirty, unclean, and smelly; blood and water spots on the floor. There were no lights in the room and not enough running water for washing and cleaning. The labour room in the hospital was crowded and there were not enough beds for sleeping after childbirth (SBA user woman 5).

The women stated that they had no genuine alternative local facilities for childbirth. Traditional birth attendants and community health assistants were the only persons supporting women during childbirth in the village. One woman said:

> ‘‘There is a Health Post in the centre of the village. However, I heard from others that there are no qualified nurses (midwives). If women have any problem they have to go to the city’’ (SBA user woman 1).

Some of the women mentioned that it was difficult to find a large sum of money for childbirth in hospital. A woman stated:

> ‘‘I spent about NRs 6,000 including transportation costs for the hospital birth. It is expensive and difficult to manage SBA services for poor people like us. My husband did not work for a week due to the hospital delivery’’ (SBA user woman 3).

Likewise, a husband described both direct and indirect costs of a hospital birth with an SBA:

> More than half of the costs go on transportation. The cost of delivery in hospital is nearly NRs 6,000 to 7,000. The average monthly income is 8,000 to 9,000 NRs if you work as a labourer. There are extra costs for hospital delivery, like food, clothes, accommodation for persons who accompany the mother (Husband 2).

c) Culture, gender, and decision making

Women living in a nuclear family (household with parents and their children, only with two generations) appeared to be more likely to be involved in decision-making than women living in an extended family, (households with two/three or more related adults and normally more than two generations). A woman who lived in an extended family said:

> My mother-in-law always pressurised us to have a baby saying that we had had no children in our family for a long time. She wanted to see a grandchild, after pressure from the family we decided to have a baby at this early age (SBA user woman 2).

Likewise, a non-SBA service user woman living in an extended family lacked involvement in decision-making saying:

> My husband was abroad during the delivery time. My parents-in-law didn't support me well. They made all the decisions about service use without asking me. I had to get permission from my mother-in-law for whatever I wanted to do. I never did anything without asking her (Non-SBA user woman 8).

Male family members had more influence in decision-making than females. An SBA non-user woman stated:

> ...In general, women do not work outside the house so they have to depend on the husband's income. People listen to men's voice more than women's in this society. If you need to borrow money, people trust a man more than a woman (Non-SBA user women 1).

A husband mentioned that childbirth is ''women's matter''. However, in the Nepalese patriarchal society, men have a major say in decision-making regarding women. He elaborated:

> ....Labour and delivery is a woman's matter. However, in our patriarchal society men have a big voice in the family. The men have more value than the women in this society in many ways. Most families have a male-headed household so he has a vital role in decision making for health seeking behaviour, education, travel, and work, etc *(*Husband 3).

Women whose husbands were in paid employment had a greater chance of involvement in the decision-making for service use. One woman described:

> ....there are positive impacts in the family if a husband has a paid job and independent income. The family members listen to your voice if your husband

> has some income. The husband can persuade his parents in decision-making for SBA service use if he has a job and income (SBA user woman 5).

Another woman commented:

> ‘‘My husband was unemployed when I was pregnant. He had no vital role in decision-making in the family. If he had had independent income, definitely he would be involved in decision-making’’ (SBA user woman 11).

Traditionally and culturally, a mother-in-law has the main responsibility of caring for her daughter-in-law in pregnancy and childbirth. One mother-in-law stated:

> “....Her first and second babies (addressing daughter-in-law) were born at home without any difficulties. Therefore, I decided not to take her to hospital for the third one’’ (Mother-in-law 1).

Participants, irrespective of the socio-economic circumstances and family living arrangements reported that mothers-in-law had an influence on SBA use. A woman observed:

> ....In our society, concerning maternity services, for example, antenatal checkups or childbirth, the mother-in-law has a big influence due to her experience. It is easier to share problems with a mother-in-law. Husbands are mostly working outside the home so they do not know much about pregnancy care (SBA user woman 15).

The participants reported that the country’s political situation was also a barrier to better health care services. For example, frequent strikes and the closure of the transportation system were barriers to reaching the hospital in time when in labour. A woman highlighted:

> ‘‘....The political parties organised frequent Nepal bandhas (strikes) which made it more difficult to go to the hospital if labour occurred on that day’’ (Non-SBA user woman 4).

Similarly, another woman, commenting on the effect of the political situation on service use explained:

> ....On the day of discharge from the hospital there was a Nepal bandha (strike) organised by the political parties. There were no transportation services at all due to that. We stayed with a neighbour in a rented room and went back home the next day (SBA user woman 3).

d) Attitude and quality of SBA services and hospital environment

Most of the women who had given birth in a public hospital with the help of SBAs commented that the staff's attitude could encourage and/or discourage SBA service use. One woman stated:

> Some of the nurses were very mouthy. They did not understand labour pain. They used very rude language saying that they are not going to have a baby in their life. A woman asked for help to change bed sheets, but a nurse told her to do it by herself. However, a few of them are very kind and polite too (SBA user woman 6).

Women were disinclined to use the services of SBAs partly because they were male, usually doctors. Women felt embarrassed about delivering with the help of a male doctor even though they felt they needed help. One SBA service user elaborated:

> The male doctors were there helping with delivery... (laughs). I felt shy but what could I do? The pain was more intense than the embarrassment at that time. I closed both eyes and did not look anywhere when male doctors were helping with the delivery (SBA user woman 1).

The women reported that the difficulty of maintaining privacy and confidentiality is another barrier to SBA service use. The hospital room was open with no curtains and no way of maintaining privacy after the baby was born, for example:

> ....The male doctor inserted his hand into my vagina and other nurses were standing looking at that (pause for a while…) maybe they were in training. I felt bad seeing that a group of people looking at me. There were no curtains and no private room so this made it difficult to change my clothes and breastfeed the baby after delivery. We could see each other and other people (visitors) could see us easily (SBA user mother 1).

Discussion

This study tried to explore women's experiences and perceptions regarding why they want or do not want to uptake SBA services during childbirth in rural Nepal. Women's lack of autonomy in decision-making, attitudes of SBAs, and quality of services affected SBA service use. More specifically, the implications of social inequality as related to caste and gender, and a lack of rural health services also affect SBA service use. Some of these barriers could be changed in the short term, e.g. training of SBAs, and with limited resources; but

others are more fundamental and impossible or too costly to change, such as the nature of the terrain affecting access to urban based facilities.

Nepal is a multicultural and diverse society with more than one hundred different castes/ethnic groups.[31] Regarding childbirth, there are differences in health beliefs, practices, and care-seeking behaviour among different cultural and ethnic groups of women in rural Nepal.[32] While there has been some positive impact on women's lives in terms of access to health services through increased awareness[33], this qualitative study suggests that it is still the case that higher caste women and those from educated and more affluent socio-economic groups make more use of health services than poor, low caste, and illiterate women. Women's lack of autonomy in decision-making is a major factor influencing use of SBA services. Limited autonomy is based on cultural and gender norms. Findings from this study suggest that there is some evidence of changing societal perceptions and cultural shifts, for example, in the existence of nuclear families (including female headed households). Additionally, some women have their own income which also has a positive impact on SBA service use. However, due to the culture and women's lack of autonomy, even better educated women may not feel able to challenge the age and gender norms in decision-making.[33] This reflects women's overall status in society as well as cultural beliefs about childbirth.

Limited involvement (even of educated women) in decision-making reflects the continuing importance of the older generation in younger women's choices. In fact, women are often culturally isolated during pregnancy and many lack knowledge about reproductive health and reproductive rights. Pregnancy is widely considered as a taboo subject based on gender norms; that pregnancy is a 'women's matter'.[11] Hence, the decision to use SBAs is affected by many traditions in societies like Nepal, for example, the lack of open discussion regarding pregnancy related matters, as these are associated with sexual activities and, sometimes, the view prevails that women should not be seen to be pregnant.[34]

The caste system still largely determines people's socio-economic position and indicates someone's status in the Nepalese society.[35] However; this study suggests that social inequality may not be as apparent in a rural community. This raises the question; whether this is partly due to political changes. The abolition of monarchy and the establishment of Nepal as a republic in 2006 may be influencing cultural changes in every aspect of people's lives. However, there are still social inequalities based on gender, caste, economic status, and place of residence affecting women's lives in many ways, including health service utilisation. Gender discrimination can be seen in the difference in the literacy rates between males (71%)

and females (46%), over 15 years, with significant implications for women's life chances and choices.[36] It is likely that these differences are higher in low caste ethnic, rural communities and deprived groups.[37]

Culturally, after marriage, it is customary for a woman to move in with her husband's family and, traditionally, most families in Nepal still live in extended families. [14, 38] As a daughter-in-law, a young married woman has to perform her duties under the supervision of her mother-in-law and follow her ideas and suggestions. In such situations the senior member of the family is the final decision-maker. Thus, a daughter-in-law, as a junior member of the family, cannot make her own decisions if her ideas and wishes do not accord with those of her mother-in-law. Conversely, in extended families, mothers-in-law have more responsibility for caring for their daughters-in-law during and after pregnancy. The gendered nature of pregnancy and childbirth generally makes it easier for the daughter-in-law to share pregnancy related experiences with her mother-in-law. However, as mentioned, the embarrassment and taboo surrounding reproductive and sexual matters may make inter-generational communication difficult, including in relation to the health needs of young women, and may also impact the use of modern health services.

By tradition, in many Nepalese communities, pregnancy and childbirth is considered to be a 'woman's issue' and men are excluded. For example, generally husbands are not allowed to be present in the labour and birth room although women may feel discomfort in an unfamiliar environment and some might want support from husbands.[39] However, in the Nepalese culture, men are considered only as resource providers with regard to health care use, and in some communities, a man is considered shameless or cowardly if he shows an interest in his wife's pregnancy in front of his family members or friends. This limited role in their wives' pregnancies and related health matters in the Nepalese culture has been noted across South Asia.[38, 40] This can be contrasted with the situation in many developed countries; for example, the involvement of partners in pregnancy matters (including at childbirth) is reported to be almost universal in the UK.[41]

Data from this study confirm that rural women face inequalities in maternal health service utilisation; these are related to poor infrastructure, such as the absence of roads; distances from hospitals; and lack of transportation services as found elsewhere.[42] These factors discourage rural women from using the services of SBAs by rendering the hospital services inaccessible and disproportionately expensive.

Continuing political instability in Nepal and frequent strikes organised by different political parties also reduce the use of SBA services, as these lead to an increase in the

financial costs and security risks for reaching health facilities. A study on armed conflict and health outcomes in Nepal has shown that the adverse political situation has had a negative effect on the use of health services, as echoed in this study as well.[43]

In addition to issues of access, this study also showed that women had concerns about the quality of maternity services provided in the public hospitals, which all the SBA service user respondents attended. Positive interpersonal aspects of maternity care are crucial for ensuring that women take up SBA services. For pregnant women, the relationship with the care providers and the maternity care system influences the uptake of service.[44] This study shows that some women who had their first babies in hospital reported changing their minds about delivering subsequent babies in the hospital after unsatisfactory experiences with SBAs, which they felt led to poor quality of care.

Lack of privacy, health workers' disrespect, and poor confidentiality are other important issues that influence whether women go to hospital for childbirth. Lack of respectful care or efforts to maintain women's dignity by SBAs in the hospital also discourages women's use of SBA services. While the women had no specific complaints about the treatment received from the medically trained staff (gynaecologists and obstetricians), there was a gender related issue, since women expressed shame and embarrassment about being examined by a male doctor. D'Ambruso and colleagues state that a positive attitude by SBAs (providing respectful care and encouragement through polite behaviour) could promote women's use of SBA services in the future, while negative attitudes (neglect, shouting, and use of rude language) are discouraging.[22] In some instances reported in this study, SBAs behaved in a superior way with women, rather than showing respect through polite behaviour and communication, which also discourages women's SBA services uptake.

Conclusion

Factors that appear to influence SBA services use include cultural factors affecting women's lack of autonomy in resource control and decision-making. Issues of access related to both the status of the respondents as members of a rural community and to the economic circumstances of individual families are also vital. The difficult terrain of the country, widespread poverty and illiteracy, and limited resources (or their mismanagement) for the improvement of existing services are also affecting SBA services uptake. Traditional and cultural attitudes and gender-related factors pose challenges when considering how policies could be changed and services developed to meet the needs of rural women who are pregnant.

However, the qualitative data about women's actual experiences of hospital based maternity care and their preferences with regard to future service use have yielded new knowledge and two findings in particular have implications for the improvement of existing services and the development of new ones. Respondents who had attended hospitals in order to receive care by SBAs generally described this as a negative experience, due to the rude behaviour of female SBAs and the poor physical standards of the facility; these have direct implications for the training and management of staff.

There have been some improvements in health outcomes in Nepal over the last few decades but there are still significant challenges related to increasing the efficiency and quality of the health services, including the training, deployment, and management of SBAs themselves. To date, women's experiences and preferences have been overlooked in service design and development, and there is a specific need for maternity service developments in the rural areas. The establishment of a fully trained cadre of midwives, operating according to a professional code of ethics, could improve the quality of care in existing facilities.

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Conflict of interest statement

The authors have declared that there is no conflict of interest.

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