

CULTURAL CHILDBIRTH PRACTICES, BELIEFS AND TRADITIONS IN LIBERIA

by

Jody Rae Lori

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A Dissertation Submitted to the Faculty of the

COLLEGE OF NURSING

In Partial Fulfillment of the Requirements
For the Degree of

DOCTOR OF PHILOSOPHY

In the Graduate College

THE UNIVERSITY OF ARIZONA

2009

THE UNIVERSITY OF ARIZONA
GRADUATE COLLEGE

As members of the Dissertation Committee, we certify that we have read the dissertation prepared by Jody Rae Lori

entitled Cultural Childbirth Practices, Beliefs and Traditions in Liberia

And recommend that it be accepted as fulfilling the dissertation requirement for the Degree of Doctor of Philosophy

Date: February 27, 2009
Joyceen S. Boyle, PhD, RN, FAAN

Date: February 27, 2009
Marylyn M. McEwen, PhD, APRN, BC

Date: February 27, 2009
Judith Berg, PhD, RNC, WHNP, FAANP, FAAN

Final approval and acceptance of this dissertation is contingent upon the candidate's submission of the final copies of the dissertation to the Graduate College.
I hereby certify that I have read this dissertation prepared under my direction and recommend that it be accepted as fulfilling the dissertation requirement.

Date: February 27, 2009
Dissertation Director: Joyceen S. Boyle, PhD, RN, FAAN

Date: February 27, 2009
Dissertation Director: Marylyn M. McEwen, PhD, APRN, BC

STATEMENT BY AUTHOR

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ACKNOWLEDGEMENTS

I would first like to thank all my committee members for their support and guidance while I have been at the University of Arizona. As chair of my committee, Dr. Joyceen Boyle, has mentored and guided me through the theoretical and practical challenges I faced engaging in international research. Her dedication and thoroughness as a mentor is unsurpassed. Dr. Marylyn McEwen challenged me to think in new ways and widely explore the potential contributions of critical ethnography in producing transformative knowledge for influencing health and social policy. Dr. Judy Berg always provided the grounding in women's health necessary to keep women at the center of this research. I would also like to express my gratitude to Dr. Kathleen May for her willingness to serve on my advisory committee.

The Institute for Research on Women and Gender and the Global Health Research and Training Initiative at the University of Michigan provided the funding necessary to carry out my fieldwork and I thank them for their support. Without the generous assistance of many individuals and agencies in Liberia I would not have been able to carry out this research. I wish to thank Africare – Liberia specifically Claudette Bailey and Denis Hynes for sharing with me their invaluable experiences of decades spent working in Africa. I would like to express my gratitude to Dr. Garfe Williams, Mary Tiah and Mary Tucker at Phebe Hospital for providing me with access and cooperation in the hospital and clinics. Also, I would like to thank Gertrude Gorma Cole and Bettie Queateh-Kalloh for their assistance and company during the many weeks of travel into remote areas of Bong County. Finally, I would like to thank Saekie Suah and James Pope for their great effort in the written translation of numerous documents needed for this study.

I would also like to thank my family. My husband, Todd Ray, for his unwavering support and encouragement, his patience and love through the years of this process and the months I spent in Africa away from home and family. For taking care of me when I returned home tired and sick from Africa. I am grateful to my children Ryan and Chris and their families, Elizabeth, Rider and Riley Recla for their love, support and humor.

I am most indebted to the women and families who opened their doors to me and shared the intimate experiences reflected in this dissertation. Without their willingness to relive the events surrounding the tragedy of maternal illness and death, none of this would have been possible.

DEDICATION

To all the women of Liberia.

And to my mother.

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ABSTRACT

Over 500,000 maternal deaths occur globally each year. Over half of these deaths take place in sub-Saharan Africa. The purpose of this study was to understand the socio-political and cultural context of childbirth in Liberia including practices, beliefs and traditions that influence maternal health, illness and death. The concepts of vulnerability, human rights related to reproductive health, gender-based violence and war trauma within the theoretical perspectives of global feminism provide the framework for this study. Critical ethnography was used to study 10 cases of severe maternal morbidity and eight cases of maternal mortality. Data collection included participant observation, field notes and semi-structured, in-depth interviews with 54 women, family members and community members. Three major themes derived from the data were *Secrecy Surrounding Pregnancy and Childbirth*; *Power and Authority*; and *Distrust of the Healthcare System*. The interpretive theory, *Behind the House*, generated from data analysis provides an effective way of understanding the larger social and cultural context of childbirth and childbirth related practices, beliefs and traditions in Liberia. It defines the complexity and challenges women in Liberia face in their reproductive health. This interpretive theory moves beyond the biomedical understanding of birth by contextualizing childbirth as a social as well as a biological process. This study provides a starting point for more relevant, sensitive and culturally congruent public health programs and policies to address maternal morbidity and mortality in this population.

CHAPTER I: INTRODUCTION

Background

Globally, over 500,000 maternal deaths occur each year (World Health Organization [WHO], 2004). This figure translates into more than 1400 childbirth related deaths every 24 hours. Nearly half of all maternal deaths occur in Africa. For every woman who dies, another 100 women survive childbearing but suffer from serious disease, disability, or physical damage caused by pregnancy-related complications. Maternal morbidity in the form of uterine prolapse, pelvic inflammatory disease, vesicovaginal fistulas, urinary and fecal incontinence, infertility and pain during intercourse are a few of the long-term consequences of pregnancy-related complications (PATH, 2005). A million or more children are left motherless each year when a mother dies from pregnancy related causes. Children who survive their mother's death are 10 times more likely to die within two years than children with two living parents (Safe Motherhood, 2007).

The Safe Motherhood initiative, a global campaign to reduce maternal mortality, was launched 20 years ago by the World Bank and two United Nations (UN) agencies — the United Nations Family Planning Association and WHO. Strategies included providing family planning services and post abortion care, promoting antenatal care, ensuring skilled attendance at delivery, improving essential obstetric care through availability of antibiotics, oxytocics, and sedatives, skills for manual removal of the placenta or retained products and assisted vaginal delivery as well as addressing the reproductive health needs of adolescents (Safe Motherhood, 2007). Despite extensive

programmatic approaches employing these strategies, little progress has been made toward making childbirth safer.

The UNs Millennium Development Goals (MDGs) set in 2000 targeted a 75% reduction in the maternal mortality ratio by 2015. The goal addressing maternal mortality, MDG #5, has made the least progress to date of all eight goals (Rosenfield, Maine & Freeman, 2006). As of September 2005, sub-Saharan Africa and Southern Asia fall into the categories of “no progress” or a “reversal in progress” with actual higher maternal mortality figures than in 2000 when the MDG were set (Graham & Hussein, 2007).

Sub-Saharan Africa continues to bear the greatest burden of maternal mortality worldwide with an average of 1000 maternal deaths per 100,000 live births; nearly 50 times higher than in industrialized countries (Ronsmans & Graham, 2006). The chance of a woman dying from complications related to pregnancy is 1 in 15 for a woman in Africa compared to 1 in 3750 for a woman living in North America (Abdoulaye, 2006).

Statement of Problem

Despite significant investments in resources and targeted interventions aimed at achieving the Millennium Development Goals, minimal progress has been made in reducing maternal mortality. Extreme inequality remains between those who die and those who survive. Why are women in the developing world still dying from childbirth related causes? Why have significant investments in resources failed to produce tangible results?

It has been recognized that violence and trauma, the lack of control over reproduction, low social status, gender discrimination, lack of educational opportunities

for girls, and patriarchal social constructs contribute to the underpinnings of maternal mortality in the developing world. Applying the attributes and concepts of human rights to pregnancy and childbirth has been advocated and described in the literature during the past decade (Cain, 2000; Fathalla, 2006; Fransen, 2003; Shaw 2006; Tinker, 2000).

Improving maternal mortality in developing countries requires not only recognition of multiple and complex factors but action toward realization of every woman's right to a safe pregnancy and birth (Freedman, 2001). Applying a human rights perspective by focusing on the concerns of women through respect for their beliefs and traditions is crucial. Every woman deserves the inalienable right to give birth in a safe and supportive environment. Any improvement in maternal mortality in Liberia will stem from our ability to understand the context of cultural influences on maternal health, illness and death.

There is currently very little information available on how Liberian women understand birth and how birth related knowledge influences maternal health. Without a clear understanding of the traditional structures surrounding childbirth as well as how problems are interpreted and understood by the women themselves progress toward reducing maternal mortality will be hampered. Effective interventions must be developed within the cultural context of a particular country or region. This program of research will focus on providing an understanding of childbirth and maternal illness and death through the lens of women, families and communities in order to generate an interpretive theory of maternal mortality and morbidity in Liberia, West Africa.

Liberia

Liberia, located on the west coast of Africa occupies 43,000 square miles (slightly larger than Tennessee) and is bordered by Sierra Leone, Guinea, the Ivory Coast and the Atlantic Ocean (Appendix A). It was settled by freed Black slaves from America. The American Colonization Society, established in 1816 by white upper-class males including James Monroe, Andrew Jackson, Francis Scott Key and Daniel Webster, lobbied Congress and the President for funds to repatriate free Blacks to Africa (Van der Kraaij, 2007). The Society was a mixture of those who wanted to provide freed African slaves and their descendants with the opportunity to return to Africa and those who feared free Blacks and wanted to expel them from the United States. In the decade that followed over 2,500 freed Blacks settled in Liberia. Colonized in 1821, Liberia, the only free republic in Africa, served as a model for many years for other African colonies struggling for their own independence (WGBH Education Foundation, 2002). These freed Blacks came to be known as “Americo-Liberians”, a term still used and recognized in Liberia today.

For the next 150 years Liberia was governed by Americo-Liberians as the new citizens became the elite ruling class with support from America and Europe. They repressed any opposition or attempts from the indigenous population to participate in the political process, leading to political and social strife in the country. Interestingly, the Americo-Liberians eventually denied the indigenous population the same human rights they themselves had so recently acquired. Men and women from indigenous tribes were forced into labor and not afforded the same privileges or protection under the law as members of the then ruling class (Reef, 2002). The outgrowth of continued oppression of

the indigenous tribes led to a series of destructive civil and rebel wars that caused thousands of deaths and tremendous social upheaval and suffering.

In 1980 the first military coup led by Samuel Doe, an indigenous master sergeant, overthrew the government. This began the series of coups and rebel wars that destabilized the country and killed thousands of people. The exodus of Charles Taylor, former President and warlord, in 2003, was the turning point for new found optimism and peace in the country. In January 2006, Ellen Johnson-Sirleaf, Africa's first elected female head of state was inaugurated following free elections. She has been ranked in the top 100 of the world's most powerful women by Forbes magazine (MacDonald & Schoenberger, 2007). Currently, there is great hope in Liberia that she will change the balance of power for women and the disenfranchised as well as stabilize the country and begin to rebuild the infrastructure.

The Current Situation in Liberia

Liberia has one of the fastest growing populations on the continent with a growth rate estimated at 2.6% and a total fertility rate of 5.2% (Liberia Institute of Statistics and Geo-Information Services [LISGIS], 2008). The devastating 14-year civil and rebel wars have left the country with a shattered infrastructure. Hospitals, clinics, and basic public sector services such as electricity and potable water have been ravaged. Currently, over 80% of the population lives on \$1US dollar per day and unemployment stands at 85% (WHO, 2004). During the vicious fighting, many towns and villages were looted and burned by warring factions. By mid-conflict it was estimated that half of the then 2.5 million people in Liberia were internally displaced or forced to flee from their homes to

neighboring countries (Swiss et al., 1998). Many women were exposed to gender-based violence and war crimes including sexual assault, murder, and rape (WHO, 2004).

The maternal mortality rate in Liberia is estimated at 994 maternal deaths with the lifetime risk of maternal death 1 in 16, ranking it fifth highest in the world for this indicator (LISGIS, 2008). Approximately 85% of infant deliveries occur in rural communities with the nearest health facility often a 12-18 hour walk (Lori, 2006). According to the Ministry of Health (MOH) there are less than 1,100 nurses, 500 certified midwives and 30 physicians in the entire country to care for the current population of 3.5 million people (D.F. Jones, personal communication, February 18, 2006).

Health Status of Liberian Women

Populations are groups of people who share a common characteristic such as place of residence, gender, or a life event such as childbirth (Aschengrau & Seage, 2008). Populations provide a unifying framework for the study of health and disease. Summary measures of population health represent the health status of a particular population often in a single number providing a global picture of a specific population. This type of data allows comparison of the health of one population to another. It also allows for the identification of overall health inequities in a population in order to establish priorities for future interventions.

Table 1 shows the overall health status of Liberian women, based on current available data. The data are compared and contrasted to women living in the U.S. This comparison highlights the stark differences between women's health status in these two countries.

TABLE 1: Comparison of Health Status Indicators

Indicators	Liberia (2007)	U.S. (2005-2007)
Population	3.2 million	300 million
Life Expectancy for Females at Birth	44 years	81 years
Healthy Life Expectancy at Birth for Females	37 years	71 years
Total Expenditure on Health per capita	\$22.	\$6697.
Maternal Mortality Rate (per 100,000)	994	14
Under 5 Mortality Rate (per 1,000 live births)	110	8
Infant Mortality Rate (per 1,000 live births)	71	7
Fertility Rate per Woman	5.2	<2.0
Coverage of Vital Registration of Deaths	<25%	100%

Life expectancy, as defined by the WHO (2007a) is the “average number of years of life that a person can expect to live if they experience the current mortality rate of the population at each age”. In Liberia, life expectancy is 44 years for women. This is comparable to life expectancy in the United States at the turn of the 20th century when life expectancy was 47.3 years for Americans (Aschengrau & Seage, 2008). In a little over one hundred years this figure has increased to 81 years for women in the U.S.

Healthy life expectancy (HLE) is based on life expectancy figures but also includes an adjustment made for time spent in poor health. This number reflects the number of years in full health a person will live based on the current mortality rates and health states of the population (WHO, 2007a). For Liberian women this drops from a life expectancy of 44 years to 37 years of HLE cutting off seven precious years of health. In the U.S. it drops from a life expectancy of 81 years to a HLE of 71 years, far surpassing Liberian women.

The total expenditure on health per capita in Liberia is \$22 per year as compared to \$6,697 per person per year in the United States (American College of Healthcare Executives, 2007; WHO, 2007a). Total health expenditure is often reported as a percentage of the Gross National Product (GNP). For Liberia, this figure is 5.6%. In contrast, the U.S. spends 16.0% of its GNP on health care, at least three percentage points higher than any other industrialized country (Kaiser Foundation, 2007). This figure is derived from the total of public and private expenditure on health. It uses the international dollar as a common currency unit to account for differences in purchasing power of various currencies (WHO, 2007a).

Maternal mortality is defined by the International Classification of Diseases, 10th edition (ICD-10) as “the death of a woman while pregnant or within 42 days (or one year for late maternal death) of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes” (WHO, 1992). Maternal mortality is often used as a marker for the health of a population. As previously noted, the Liberian maternal mortality rate is 994 maternal deaths per 100,000. In comparison, maternal mortality in the U.S. is 14 maternal deaths per 100,000 (WHO, 2007a).

The under-five mortality rate in Liberia is 110 per 1,000 live births. This is the probability of a child dying before reaching the age of five. Liberia ranks 43rd out of 46 countries in Africa reporting this indicator. In contrast, the United States under-five mortality rate is 8 per 1,000. This is perhaps a reflection of the maternal mortality rate as

infants left motherless by a maternal death are much more likely to die in the developing world (Safe Motherhood, 2007).

The infant mortality rate is the probability of a child born in a specific year dying before reaching the age of one. Liberia's infant mortality rate is reported as 71 per 1,000 live births. Of the WHO's 193 member states in 2005, Liberia ranked 190th on this indicator with Afghanistan and Sierra Leone the only other countries with a higher rate (WHO, 2007a). The U.S. rate for infant mortality is 7 per 1,000 live births.

The fertility rate, defined as the average number of children born to a woman over her lifetime is 5.2 for Liberia (LISGIS, 2008). Fertility levels remain above 5.0 in only 35 of the 148 developing countries in the world. Very rapid population growth is expected in a small number of developing countries. The population is projected to at least triple in a handful of countries including Liberia over the next 50 years (United Nations, 2005). The fertility rate in the U.S. currently stands at less than 2.0.

Finally, the coverage of vital registration of deaths is remarkably low in Liberia at less than 25%. This is not unusual in the developing world. Multiple factors contribute to this including lack of an adequate infrastructure for a vital statistic system, the fact that most births and deaths occur in the home without a skilled health care provider in attendance, and in many cases no cause of death is ever established when a death occurs. Graham and Hussein (2007) report in many parts of the developing world births and deaths remain unrecorded. Inadequate and inaccurate understanding impedes the ability to target activities, plan appropriate culturally sensitive programs or evaluate interventions. Because of the recent brutal civil wars and abject poverty, very little

reliable data are available on the burden of disease in Liberia. In the rural areas, where most of the population lives, no birth or death certificates are issued. In contrast, the U.S. is reported to have 100% coverage of vital registration (WHO, 2007a).

Purpose of Study

In order to facilitate future integrated strategies to address maternal morbidity and mortality in Liberia, this study describes aspects of the broader cultural context of childbirth in Liberia. This beginning program of research focuses on providing an understanding of childbirth and maternal illness and death through the lens of women, families and communities. The purpose of this study was to understand the socio-political and cultural context of childbirth in Liberia including practices, beliefs and traditions that influence maternal health, illness and death.

Research Questions

This study addressed the following two research questions:

1. How do Liberian women, family members and community members understand and describe maternal illness and death?
2. What are the political, social and cultural factors that influence the ways women seek care during pregnancy and childbirth?

Significance of the Study

No woman should die giving birth. All women deserve the right to a safe childbirth experience. Developing a human rights based approach to reduce maternal mortality is directed by an understanding of the inequities women face in the developing world. Understanding the cultural context of childbirth and how Liberian women

understand and interpret maternal mortality will allow the future design and implementation of programs that deliver more sensitive, culturally relevant care. How women understand and interpret the horrendous maternal illnesses and deaths in their country can help devise programs to decrease maternal morbidity and mortality at a national level. Until the underlying factors related to women's human rights are addressed, the conditions to change the enormous disparities between the levels of maternal mortality in developing and developed countries cannot be addressed. Available, accessible, and culturally acceptable services must be provided to all women.

Culture has a profound influence on beliefs and practices of childbirth. Cultural beliefs and traditions associated with childbearing touch all aspects of life in a given culture (Callister, 1995). The ways in which an individual society views and manages childbirth are dependent on the beliefs, practices, and values associated with reproduction, health, and the role and status of women (Lauderdale, 2003). Knowledge gained by illuminating the cultural context of how Liberian women understand birth and how birth related knowledge influences maternal health sets a broader framework for addressing maternal mortality rates. This knowledge can then be applied to developing approaches that include recognition of human rights in addressing maternal morbidity and mortality.

Theoretical Perspective

The praxis of feminist theories has been developing over time. Feminist theories have evolved from a binary theory with the concepts of "woman" versus "man" to a relational theory informed by the concepts of class, race, gender, religion, society,

sexuality and others (Armbruster, 2007). Feminist theories help to generate understanding by explaining phenomena women find significant, important, or fundamental to their lives (Anderson, 1995). The ontology of feminist theory is to create a social system that implements the ideology of equality, changes oppressive constraints and brings about change through criticisms and political action (Bent, 1993; Hall & Stevens, 1991; Parker & McFarlane, 1991).

Global feminist theory, which is woman centered, served as the perspective for a critical interpretive ethnography to provide an understanding of childbirth and maternal illness and death through the lens of women, communities, and families. At the core of the theory is the examination of oppression as a result of colonial and nationalist policies and practices. Global feminist theory can help to raise consciousness and challenges traditional power relationships. One of the most useful elements of this theory is the strength of promoting the research process as a reciprocal relationship between the participants and the researcher (Tong, 1998). Additionally, global feminist theory supports a human rights approach to examine the cultural context of childbirth in Liberia.

Global feminism has its roots planted in cultural, racial and ethnic issues. A central tenet of global feminism is that women from the developing world experience oppression differently than women from the developed world. Just as Collins (2000) and hooks (2000) have challenged the ideals of liberal “white” feminism, global feminism pushes to the forefront political and economic issues that impact women’s lives. Concepts central to the theoretical underpinnings of global feminism include removing inequity and oppression through a more just social and economic order (Bunch, 1993).

Women experience various forms of oppression unique to their lives. Women who share similar life circumstances often experience oppression in similar ways. Relational statements in global feminism link women's oppression to colonial and nationalist policies and practices (Tong, 1998). Global feminist theory is far more concerned with how political and economic issues impact women's lives versus gender or sexual issues. It focuses on uniting women from all parts of the world to discuss their commonalities as well as differences in order to impact change. Global feminist theory provides a perspective from which to examine the oppression of women in the developing world.

Linking Global Feminist Theory and Liberian Women

Women in Liberia have been oppressed by war, trauma, and human rights abuses. Gender-based violence and trauma have become part of everyday life over the past two decades of war and dislocation for Liberian women. Violence against women is now recognized as a public health problem and a human rights violation (Krantz & Garcia-Moreno, 2004). Studies show women suffer long-term psychological effects as well as manifestation of physical illness as a result of gender-based violence associated with war with a potential devastating effect on sexual and reproductive health (Ellsberg, 2006; Igreja, Kleijn, & Richters, 2006).

A theoretical perspective of global feminism required a qualitative study design. It provided the context for the research process including framing the research question and assisting in data analysis. It infused the research process with feminist values and raises the consciousness of the researcher.

“For global feminists, the personal and the political are one.” (Tong, 1998, p. 227). Using global feminist theory as the lens to explore the underlying cultural practices, beliefs and traditions that impact maternal health in Liberia helped to establish a true partnership with Liberian woman. It helped uncover factors central to Liberian women’s lives that had been overlooked or unconceptualized (Stewart, 2000). Global feminist theory allowed the researcher to understand the experience from the perspective of the woman’s life. A fuller understanding of the larger social context affecting maternal morbidity and mortality provides a clearer picture of this particular human experience. Global feminist theory which values women and women’s experiences, served as the theoretical perspective to guide this study.

Summary

Maternal mortality has long been a cornerstone used to gauge the health of a country and its citizens. Despite unprecedented efforts over the last 20 years, little to no progress has been made in changing the rates of maternal mortality in developing countries. Global feminist theory provided the basis for the logic of this study. It links all aspects of the study as described in this proposal.

Illuminating cultural childbirth practices, beliefs, and traditions has important implications for future development of public health programs and policies. The overall purpose of this study was to understand the socio-political and cultural context of childbirth in Liberia including practices, beliefs and traditions that influence maternal health, illness and death. The larger program of research focuses on providing an understanding of childbirth and maternal illness and death through the lens of women,

families and communities in order to generate an interpretive theory of maternal mortality and morbidity in Liberia, West Africa. Improving maternal mortality in developing countries requires not only recognition of the problem but action toward realization of the right to a safe pregnancy and birth (Freedman, 2001).

CHAPTER II: REVIEW OF LITERATURE

The literature on maternal morbidity and mortality is vast. The purpose of this review is to provide an overview of the literature focusing on maternal morbidity and mortality in the developing world as well as what is specifically known about Liberia, West Africa. It provides a context for the research study as well as identifying gaps in the literature. Following the review of literature on maternal morbidity and mortality, a review of the literature pertinent to the related concepts of vulnerability, human rights related to reproductive health and gender-based violence and war trauma is presented.

Maternal Morbidity and Mortality

Approximately 53 million women give birth at home each year without the help or benefit of a skilled delivery attendant (Sibley & Sipe, 2003). These women often live in rural, isolated communities with little access to resources including a formal health care system and transportation. They often deliver their babies alone, with the help of a family member or with an untrained traditional birth attendant (TBA). Complications arising from pregnancy and childbirth are the leading cause of death and disability among reproductive age women in the developing world (Tinker, 2000). Worldwide, over 500,000 women die every year from childbirth complications and many others suffer life-long morbidity. Ten to twenty million women suffer severe health problems related to pregnancy (Obaid, 2007). Roughly 4 million neonates die before they reach the end of their first month of life (WHO, 2006a). The WHO (2006a) advocates a skilled attendant for every delivery yet in developing countries with limited resources and a high number of home births this is a distant reality.

We are now past midpoint in the timeline (2000-2015) toward achieving the Millennium Development Goals with very little progress to date. Twenty-two years ago the Safe Motherhood initiative was launched to reduce the global burden of pregnancy related illness and death. Today, most of that burden remains unchanged. Specifically in sub-Saharan Africa very little improvement has been made in the past two decades.

In their seminal article, Thaddeus and Maine (1994) described three phases of delay as operational factors contributing to maternal death: delay in deciding to seek care; delay in reaching an adequate health facility; and delay in receiving adequate care once at the health facility. Beliefs as they relate to illness causation and maternal complications are central to the decision making process to seek care. Recognition of illness in the developing world is often not defined by the biomedical model but rather by the person's view of reality. Additionally, gender inequalities exacerbate the situation. In many countries women may not have the social status to make their own decisions regarding care which is often in the control of a spouse or more senior member of the family. Women also often lack control over resources such as access to money for transportation or care.

There is a need for community-based strategies using contextual information with targeted programs in addition to the many broad, high profile strategies, such as intrapartum care based in health facilities, currently underway. There is no doubt every woman deserves a skilled attendant to care for her during her pregnancy and childbirth but in many developing countries the infrastructure and resources in human capital to support this strategy do not exist (Costello, Azad & Barnett, 2006). Community based

strategies consider the social system, the understanding of birth, customs, beliefs and values of communities and indigenous people. Community based partnerships ensure the development of strategies match the values and resources of the community. The value of any strategy is linked to not only the evidence base but also the context for the application of the evidence. Roth & Mbizvo (2001) call for a better understanding of maternal health needs and priorities as defined by communities. Qualitative methods are needed that incorporate not only focus groups and interviews but observational data from the community and the formal and informal health sectors to shed light on the context within which people make health decisions. In their review of the literature, Bullough et al. (2005) highlight the multifaceted determinants of maternal mortality. They state “a country’s socio-economic, cultural, political and religious context influence(s) the health of the population” (Bullough et al, 2005, p. 1181). They specifically list inequality in decision-making authority and inaccessibility of safe abortions as two contextual factors impacting maternal mortality.

In a 17-year review of maternal mortality in Nigeria, Ujah et al. (2005) examined factors that contributed to the failure of Safe Motherhood initiatives. They found a continuing increase in maternal mortality in Nigeria and other parts of sub-Saharan Africa can be partly attributed to social and political factors. Suggestions are made for additional studies among women of childbearing age to identify barriers to care as well as the development of region-specific programs that consider the social, cultural and religious beliefs.

The influence of men, both positively and negatively, on women's reproductive health has been examined by medical anthropologists. In a literature review of men's influence on women's reproductive health Dudgeon & Inhorn (2004) found men's influence on pregnancy and childbirth is poorly understood with few studies including the male partner's influence on pregnancy or the role of men in pregnancy care and obstetrical outcomes. Most studies on reproductive health consistently target only women. Only one study in this review conducted by MotherCare, an international non-government organization, investigated the roles men play during obstetric emergencies or men's experiences of obstetric emergencies. They identified the role of men as key in negotiating decisions during obstetrical emergencies in Guatemala. Roth and Mbizvo (2001), in a review article advocating for inclusion of men in Safe Motherhood strategies, identify the complex interplay of social, cultural and economic factors that contribute to the high rates of maternal mortality in Africa. The influence of male partners on women's reproductive health is complex. Men are often important gatekeepers of reproductive health care even though they may lack necessary knowledge about this care.

AbouZahr (2003) reminds us that simple transfer of medical care models from industrialized countries to developing ones will not work. An understanding of the social, economic, and political causes contributing to ill health in each specific country must be included. There is a long chain of factors that contribute to the reproductive vulnerability of women in the developing world. These include poverty, social status in the family and community, discrimination in access to basic health care services and lack of education to name a few. Economic and social vulnerability play an important role in the wider

context of maternal mortality. Aspects of women's perception of risks, the degree they are bound by cultural norms and practices, limited decision-making power, and overall status in society affect women's access to and utilization of health care.

Each of these studies highlights the importance of understanding the cultural context of childbirth. Multiple and complex factors contribute to the lack of progress toward reaching the Millennium Development Goals. Maternal mortality is one of the most striking inequities in public health throughout the world. The death of a mother has far reaching effects on economics, communities, and families. Queenan (2007) in a very succinct summary stated "We cannot progress toward better health care for poor mothers if we do not clearly assess the current needs and determine what must be done and how best to do it" (Queenan, 2007, p. 968). A major goal of this study is to understand the larger social and cultural context of childbirth including childbirth related practices, beliefs, and traditions in order to generate an interpretive theory of maternal mortality and morbidity in Liberia, West Africa.

Childbirth Beliefs and Traditions

Conceptualizing childbirth by understanding cultural beliefs and traditions provides a mechanism to further explore how wider societal factors impact maternal mortality and morbidity. Understanding these factors can then aid the development of culturally congruent interventions aimed at reducing maternal mortality and morbidity.

Amooti-Kaguna and Nuwaha (2000) published findings from a qualitative study conducted in southwest Uganda that examined the role of psycho-social factors influencing delivery site. They found the social influence of the husband, other relatives,

and the traditional birth attendant contributed to the disparity between the high portion of women attending antenatal care and the small portion of women who then go on to deliver in health facilities. The concept of pregnancy as a normal event not requiring medical care contributed to women's decision-making to remain in the home for delivery.

Several ethnographies have been published focusing on childbearing women in the developing world. Each contributes to our understanding of childbirth practices, beliefs and traditions. An ethnography of 38 Tibetan women was conducted by Adams et al. (2005) to examine women's beliefs and behaviors surrounding pregnancy and childbirth. They found that fear of attacks by spirits and demons precluded a woman traveling at night to a health center or clinic. They also found Tibetan women believed they would experience negative health effects from interactions with strangers contributing to underutilization of health care services. Additionally, because of a fear of pollution or defilement from the spirit of those persons who had previously died in a hospital, women chose not to access hospital care. Jensen (2006) undertook a mini-ethnographic study (n=5) to describe and understand the traditional structures of childbirth in Ghana and to explore why pregnant women do not use supervised deliveries in modern institutions. She found pregnant women were not responsible for decision-making related to accessing care during pregnancy and childbirth. Responsibility for decisions related to place of delivery were relegated to older female relatives.

Chapman (2006) found women strategically utilize plural health care systems (traditional and biomedical) in order to minimize both social and biological harm in central Mozambique. Her in-depth ethnographic study of 83 women during pregnancy

and after childbirth highlights the extreme structural and cognitive gaps between the biomedical constructs of risk and the social threat perception of childbearing women in Mozambique. Women believed public knowledge of their pregnancy increased their vulnerability from spirits or witchcraft. The women in this study did not consider the prenatal services provided at the clinic adequate to meet their spiritual and interpersonal needs during pregnancy. To fill this gap they utilized the informal or lay sector of health care providers minimizing their contact with formal medical providers.

Even when a formal health care system with quality care is available many women believe these services are not appropriate for childbirth. A context specific understanding of practices, beliefs and traditions related to childbirth is needed in communities and countries with high maternal mortality. Without this knowledge there is inadequate understanding and guidance about how to proceed (Costello, Azad & Barnett, 2006). Many of the interventions adopted over the past twenty years of the Safe Motherhood initiative have focused on the core strategy of skilled attendant and health center based childbirth. Not only is this strategy not achievable in many developing countries because of lack of infrastructure and human capacity, it is not culturally congruent with childbirth practices and beliefs in many countries. For example, many women prefer to be attended in childbirth by indigenous healers who understand the community norms and customs (Adams et al., 2005; Berry, 2006; Chapman, 2006).

Two ethnographies, focusing on pregnancy and childbirth in Guatemala, (Berry, 2006; Callister & Vega, 1996) noted themes related to the sacred nature of childbirth and reliance on God during pregnancy, childbirth, and childrearing. Biomedical information

about the dangers of birth failed to fit into the traditional cultural understanding of birth by indigenous women in Guatemala. Both studies found a strong desire among Guatemalan women to give birth at home surrounded by their families. The quality of their birth experience was highly influenced by where they gave birth. Most women preferred to remain in their villages and homes even when problems manifested during labor.

A qualitative study using phenomenology with in-depth interviews of 30 women in Thailand found traditional childbirth practices have gradually diminished in Chiang Mai, Thailand as they have been replaced by the medicalization of childbirth (Liamputtong, Yimyam, Parisunyakul, Baosoung & Sansirihun, 2005). The social meaning of childbirth continues to be part of the larger social system involving the woman, her family, society and the supernatural world but women are blending the biomedical model with traditional practices. This study took place in an urban city in northern Thailand. As Thailand has modernized, childbirth has moved into the hospital under physician control superseding traditional childbirth practices. Those women still adhering to traditional cultural beliefs were more likely to be from rural areas or poor urban women.

A qualitative study to explore childbirth beliefs and practices in Zambia interviewed 36 women who accompanied laboring women to rural and urban maternity units (Maimbolwa, Yamba, Diwan & Ransjo-Arvidson, 2003). The investigators found that women who provided social support to laboring women lacked an understanding of the causes of obstetrical complications during childbirth and lacked knowledge of

appropriate labor management. In addition they found indigenous knowledge and ways of knowing existed alongside modern medical care. They concluded staff at the health centers should develop a programmatic approach to integrate the social support networks of childbearing women into the formalized medical system. The study encourages policy-makers as well as providers to use culturally specific knowledge to guide the development of Safe Motherhood initiatives.

Okafor (2000) in a study to identify and address the underlying cultural factors related to maternal mortality and morbidity in Nigeria found rural Nigerian women hold a magico-religious perspective of childbirth and health care which collides with the bio-medical system of care with its emphasis on risk assessment and modern scientific evidence. These beliefs contribute to the underutilization of prenatal and childbirth delivery services at the hospitals and clinics. They also lead to delay in accessing services when a complication arises during pregnancy or birth. Awosa-Omorodion (1997) states “there is an urgent need...to look into women’s reproductive health problems in context of the conditions in which they live....” (Awosa-Omorodion, 1997, p. 1823). Using data from focus groups conducted in eastern Zaire, she found women believe most health problems arise from one’s sins and that pregnancy complications are the result of these sins including extra-marital affairs or bewitching by a spouse. She also found that women believed those who attempted to control pregnancy and childbirth would be plagued with illness or a woman’s family member would experience an illness which may cause death. If this did not happen, then it was believed that the woman risked becoming infertile in

her reincarnation. She also noted that indigenous women in eastern Zaire do not have great faith in modern medicine and prefer to use traditional treatments.

Understanding the complexities of underlying factors that may contribute to maternal mortality is needed for change to occur. Women in developing countries often have less personal autonomy, less freedom, and less access to information than their male partners (Filippi et al., 2006). While biomedical knowledge is privileged over other ways of knowing in western culture, it is not necessarily the authoritative knowledge (Jordan, 1997) for childbearing women in Liberia. As revealed in this review of current literature, cultural traditions and beliefs impact upon the utilization of obstetrical health care services. Little change has been seen in the maternal mortality rate in sub-Saharan Africa in the past 20 years. Few studies have included men or community members in their study design to examine childbirth related illness and death. This study provides the beginning for a deeper understanding of childbirth and maternal illness and death through the lens of women, communities and families. It provides information about the larger social and cultural context of childbirth. The major purpose of this study was to understand the socio-political and cultural context of childbirth in Liberia including practices, beliefs and traditions that influence maternal health, illness and death. This knowledge will be helpful in planning and implementing public health programs and policies to address the high rate of maternal mortality and morbidity in the future.

Concepts of Vulnerability, Human Rights, Gender-based Violence and War Trauma

The concepts of vulnerability, human rights and gender-based violence and war trauma are interrelated and interdependent to childbirth in the post conflict country of

Liberia. Linking these concepts under the theoretical perspective of global feminism will provide the organizing framework for this study.

Vulnerability

Vulnerable populations challenge our thinking and push us to examine creative interventions to address their needs. According to Spiers (2000) “vulnerability is a fundamental aspect of how people experience health and is a key concept in nursing” (Spiers, 2000, p. 715). There are several general characteristics that contribute to a population’s vulnerability. These can be human, social or economic in nature. The absence of others to care for you, living in an unsafe environment, abusive and chaotic relationships, as well as unemployment are some characteristics associated with vulnerable populations. Lack of social networks, unsafe living situations, poverty, and food insecurities also contribute to vulnerability. Low levels of education as well as gender, race and social class play a role in vulnerability. Fragile families, single parent households, and chronic stress are also characteristics identified with vulnerable populations.

Flaskerud and Winslow’s (1998) model for the study of vulnerable populations includes in their definition of vulnerable those persons who are “politically marginalized, disenfranchised, and denied human rights” (Flaskerud & Winslow, 1998, p. 70). There are many contributing factors to vulnerability in this model including relative risk, resource availability, low socio-economic status, violence, and crime. This conceptual framework considers the inter-relationships as a triad of resource availability, relative risk, and health status (Flaskerud & Winslow, 1998). Lack of resources increases relative

risk. Increased exposure to risk factors increases morbidity and mortality. Morbidity and mortality then potentially impact resource availability further depleting societal and environmental resources.

Aday (2001) defines vulnerability as being “susceptible to harm or neglect, that is, acts of commission or omission on the part of others that can wound” (Aday, 2001, p. 1). Aday (2001) views all of us as potentially vulnerable. The approach of this framework is on both a macro level ascribed to the community and a micro level addressing the perspective of the individual. The framework draws on historical characteristics of U.S. society, including individual rights and the collective common good. Emphasis is placed on individual rights, autonomy, and independence. For example, good health is viewed as “primarily a function of personal lifestyle choices, and poor health outcomes result because individuals fail to assume adequate personal responsibility for their health and well-being” (Aday, 2001, p. 2). The limitation of this First World view does not take into account the communal way of life observed in Africa where less emphasis is placed on individual rights than in the United States. In addition, there is little personal choice in terms of lifestyle in Liberia.

Delor and Hubert (2000) include violence, poverty, and socio-economic elements as antecedents to vulnerability in their concept analysis of vulnerability. They identify three levels of influence on vulnerability; they are social trajectory, the interactions of individuals or groups and the social context in which these interactions take place. These three levels are then described for the aggregate and the individual. The types of social relationships that exist between individuals or groups are presented as elements that

influence vulnerability (Delor & Hubert, 2000). This approach is more congruent with the emphasis of community or village life in Africa. Approaching vulnerability within the context of the recent civil war in Liberia allows the inclusion of socio-cultural factors to understand the influence of practices, beliefs, and traditions on maternal health.

Significant cogent attributes of vulnerability include defenselessness, limited resources, poverty, the denial of human rights, marginalization, and characteristics that increase relative risk. Vulnerability is complex and is most often viewed from a population-based or epidemiological risk perspective. Yet vulnerability is also a highly individualized process (Purdy, 2004). “People experience the troubles and turmoil of life in ways that cannot be captured simply by biomedical comparison to normative standards of risk” (Spiers, 2000, p. 715). According to Wilkinson (2006) population health is “sensitive to particular dimensions of the wider social structure and environment” (Wilkinson, 2006, p. 354). Vulnerability is influenced by the circumstances in which people live their everyday lives. Income, jobs, education, and housing all contribute to economics and human capital. In Liberia, over 80% of the population lives on \$1US dollar per day and unemployment stands at 85% (WHO, 2004).

Illiteracy is high among women in Liberia. Estimates from the LISGIS (2008) place male literacy (15 years+) at 70% and female literacy (15 years+) at 41%. Public education is not mandatory in Liberia. School fees, although low at \$200-300 U.S. dollars per year, per child, are more than the average Liberian makes in 6 months. When a family can afford to send one child to school it is often the oldest male in the family, reflected in

the country's literacy rates. Additionally, schools tend to be located in more urban areas of the country making access to education difficult for many rural families.

Spiers (2000) further distills the attributes of vulnerability, differentiating between the well-known externally evaluated risk (etic) and an experiential (emic) perspective. This experiential state includes a person's individual capacity for action, the level of integrity in their life, and how a challenge to this integrity is perceived. Women are especially vulnerable in the developing world as will be seen in the next two sections on human rights and gender-based violence and war trauma.

Human Rights

It is close to sixty years since the Universal Declaration of Human Rights was adopted by the General Assembly of the United Nations granting men and women the right to life, liberty and security of person. In 1986, the African state members of the Organization of African Unity adopted the African Charter on Human and Peoples' Rights (1986) proclaiming "every individual shall be entitled to respect for his life and the integrity of his person" (African Charter on Human and Peoples' Rights, 1986, p. 3). Following this in 2003, the African Commission on Human and Peoples' Rights adopted a protocol on the rights of women in Africa. Included in the 32 articles is the right to dignity, the right to life, integrity and security of the person, as well as the right to protection in armed conflicts and the right to health and reproductive rights (African Commission on Human and Peoples' Rights, 2003). Notwithstanding, human rights abuses continue to be all too common in the developing world and post-conflict countries. Relentless violation of basic human rights disproportionately affects women in

the form of gender-based discrimination, equal opportunity for education, poverty, patriarchal social constructs, equal access to health care, equality in deciding number and spacing of children, and gender-based violence. According to Yanda, Smith & Rosenfield (2003) “resource poor women face greater maternal mortality and morbidity, suffer continuous risk because of a lack of access to adequate reproductive health services, and are likelier than more affluent women to resort to unsafe, inaccessible, and/or unaffordable abortion services” (Yanda, Smith & Rosenfield, 2003, p. 275). Rights to reproductive health care are frequently violated in the developing world.

Research is sparse on the role of human rights in maternal morbidity and mortality although many policy papers exist on the subject (Cook & Dickens, 2002; Fathalla, 2006; Freedman, 2001; Yanda, Smith & Rosenfield, 2003). Maternal mortality in Afghanistan was used as a proxy indicator for women’s human rights in a study by Amowitz, Reis & Iacopino (2002). Their research focused on assessing maternal mortality and women’s human rights in Herat, Afghanistan. Using the Sisterhood Method they found the Taliban’s restrictions on women’s human rights have had devastating health consequences on women’s health. The Sisterhood Method for estimating maternal mortality was devised in the late 1980’s by the World Health Organization (WHO, 2007b). Information is obtained by interviewing respondents about the survival of all their adult sisters as a population-based survey to estimate maternal mortality. The study used a cross-sectional survey of 4,886 Afghan women who provided maternal mortality data on 14,085 sisters. There were 276 maternal deaths reported, 92% from rural areas. Eighty-seven percent of women reported they had to obtain permission from their

husband or male relative to seek health care, only 12% used birth control although 23% desired to use birth control, 0.9% reported a trained health care worker was present at the birth, while 97% were attended by an untrained traditional birth attendant. In the seven districts of the Herat Province only 17 of 27 listed health facilities were functional with five providing essential obstetric care (Amowitz, Reis & Iacopino, 2002). Additionally, the women reported problems such as access to adequate food, shelter and clean water.

In a similar study by Amowitz, Kim, Reis, Asher & Iacopino (2004) to assess the nature and scope of human rights abuses with a focus on women's rights in Iraq, 1991 respondents were interviewed from three major cities in southern Iraq. Respondents were mainly Arab ethnicity and Muslim Shi'a. Neither men, nor women in this case, supported a full range of human rights for women. Over 50% reported there were reasons to restrict educational and work opportunities for women as well as freedom of movement for women and agreed a man has the right to beat his wife if she disobeys him. This has far reaching implications for women's health. Literacy and wealth have been associated with a higher utilization of skilled birth attendant in developing countries (Krug, Prescott & Galea, 2008).

“Critical to improving maternal and newborn health outcomes is the recognition that safe motherhood and birth are human rights” (WHO, 2003, p. 16). Health is driven not only by the policies of international organizations but also by the social and cultural context in which it exists (Freedman, 2001). In order to understand the complex web of maternal mortality we must understand childbirth and maternal illness and death through the lens of women, families and communities. Maternal morbidity and mortality are not

just health problems. They are human rights issues that uniquely affect women. The failure to endorse these inalienable rights contributes to the lack of progress in reducing maternal mortality in the developing world.

Gender-based Violence and War Trauma

Practices of gender-based violence and trauma are timeless. The phenomenon of wartime rape has been traced back to the Torah and was written about in Homer, the Anglo-Saxon chronicles, and in mythology with the rape of the Sabine women (Gottschall, 2004). In 1993 the United Nations Declaration on the Elimination of Violence Against Women defined violence as “any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life” (United Nations Declaration on the Elimination of Violence Against Women, 1993, p. 1). Gender-based violence has always existed but only recently has it been recognized as a human rights problem and brought to attention in international forums. Its prevalence is difficult to determine, but has been stated to likely “affect at least one-third of women at some time in their life” (Tavara, 2006, p. 395). In war torn countries this number is potentially much higher yet it is rarely included in programmatic approaches targeting reproductive health care for women. In a UNICEF (2005) report on the impact of conflict, 733 randomly selected women were interviewed following the armed conflict in Sierra Leone. Of these, 20% were girls age 6-17 years. Three hundred and eighty three (52%) reported they had been subjected to

sexual violence. Three hundred and forty five (47%) had been raped and 192 (26%) reported having been gang raped.

Gender-based violence and trauma has become part of everyday life over the past two decades of war and dislocation for Liberian women. Two studies (Omanydondo, 2004; Swiss, et al. 1998) on war related violence in Liberia found 100% and 49% of childbearing women respectively reported experiencing physical or sexual violence during the recent civil war. Women reported experiencing multiple violent acts during the conflict including but not limited to rape, being beaten, threatened with a weapon, deprived of food and water, stripped of their clothing, and detained against their will. Victims reported suffering from psychological (i.e., humiliation, sense of powerlessness, depression, insomnia) as well as physical disturbances (i.e., lower abdominal pain, vaginal burning and discharge, dyspareunia, epigastric and generalized pain) affecting their daily lives and relationships with family and community.

Additionally, the International Rescue Committee (2004) reported in a series of focus group discussions and individual interviews held in refugee camps in Liberia immediately following the war that women reported being regularly exposed to rape, sexual abuse and prostitution in the camps. They found very young girls were especially targeted for rape. While refugee camps and camps for internally displaced persons are often seen as a sanctuary from harm, they can be highly volatile places of continued violence. In refugee camps for Liberians in Sierra Leone, 74% of women and girls interviewed reported having experienced at least one incident of sexual violence before

being displaced and 66% reported at least one incident during displacement either in or outside the camps (Watchlist, 2004).

Two studies from the aftermath of the war in Bosnia and Herzegovina (Klarlc, Klarlc, Stevanovic, Grkovic & Jonovska, 2007; Loncar, Medved, Javanovic & Hotujac, 2006) describe the long term psycho-trauma and psychological consequences of rape and repetitive traumatic war events on women. Symptoms included depression, social phobia, PTSD, and sexual dysfunction. Klarlc et al. (2007) surveyed 367 adult women in postwar Herzegovina. They compared 187 women who were exposed to war and post-war trauma with 180 women who experienced the war only indirectly through military drafting of their family members and friends. They found a significantly higher prevalence of post-traumatic stress disorder and psychological symptoms 10 years after the war in the women directly exposed to trauma. Loncar et al. interviewed 68 women in their study who were victims of rape during the 1992-1995 war in Croatia and Bosnia and Herzegovina. They found a high prevalence of depression as well as feelings of worthlessness and disgrace. Women tended to avoid social interactions and 25 victims reported suicidal ideations.

Women in two studies from Mozambique following three decades of war reported 'injury to the spirit' manifest by loss of vitality, the will to sustain life, preoccupation with individual violation and suicidal ideation (Sideris, 2003). Women also reported sleep disturbances, unstable relationships with family, and spirit possession (*gamba*) affected their capacity to conceive and raise children thereby contributing to a marginalization of their social position (Igreja, Kleijn & Richters, 2006). Both studies

looked at the long term effect of gender-based violence on the lives of women long after the end of war and found long term consequences.

In several of the studies done in Africa (Almedom et al., 2003; Igreja, Kleijn & Richters, 2006) the main resources identified by the women to aid in their healing from the traumatic events were traditional medicine and religious healers. Traditional birth attendants were seen as a vital link between the traditional system and the modern medical facilities. Aldemon et al. conducted a qualitative study of 104 women and 124 men in Eritrea to understand local perceptions of factors believed to mitigate the psychological distress in war-affected settings. They found maternal psychosocial well being was maintained by traditional systems of support including traditional birth attendants as well as traditional practices during pregnancy and childbirth. Igreja et al. used both quantitative and qualitative methods to explore the psychosocial effects of the civil war in Mozambique with 91 adult women. They reported numerous traumatic experiences with continued disturbances including sleep disturbances, deteriorating marital relationships, family instability, fertility problems and continued physical violence within the community. The majority of women sought relief for their problems from religious healers and traditional medicine forgoing organized medical care.

The long term consequences and impact on reproductive health for victims of gender-based violence are horrendous. They can include genital trauma, sexually transmitted infections, unplanned and unwanted pregnancy, as well as long term psychological consequences such as depression, anxiety, suicidal behavior, social phobias, post-traumatic stress syndrome and rape trauma syndrome (Tavara, 2006). The

intersection of gender-based violence and its long term effect on maternal health and illness has profound potential. Boyle and Bunting (1998) call for nurses “to break the silence and taboos about the subject of (wartime) rape” (Boyle & Bunting, 1998, p. 33). Addressing gender-based violence in any setting is difficult. Addressing its potential impact on maternal health and illness in Liberia is essential.

Summary

The body of evidence reviewed in this chapter suggests the global burden of pregnancy related illnesses and death in the developing world has not changed despite extensive programmatic approaches. Studies focused on childbirth beliefs and traditions suggest underlying cultural complexities and an understanding of childbirth that fails to fit the biomedical paradigm of the medicalization of childbirth. Many women in developing countries prefer to deliver at home in the care of traditional birth attendants or healers who understand the norms and practices associated with childbearing in their culture. Women often will not seek the assistance or care of a professional provider even when problems arise. Gaps in the research exist in our understanding of childbirth and maternal illness and death through the lens of women, families and communities. An unfortunate aspect of the biomedical paradigm is the thorough lack of contextual information. We know a one size fits all strategy does not work. Exploring how maternal health, at the individual level, is influenced by the broader current socio-political context of Liberia helped to illuminate the socio-political and cultural context of childbearing in Liberia including practices, beliefs and traditions that influence maternal health, illness and death. By applying a human rights perspective focusing on the interest of women,

more relevant, sensitive and culturally congruent public health programs and policies can be developed for the country that will address the high rates of maternal mortality.

CHAPTER III: METHODOLOGY

Study Design

This qualitative study uses critical ethnography to provide an understanding of childbirth and maternal illness and death through the lens of women, families and communities. The purpose of this study was to understand the socio-political and cultural context of childbirth in Liberia including practices, beliefs and traditions that influence maternal health, illness and death.

Selection of a research methodology is driven by the questions one asks, the type of results the researcher wishes to obtain and the anticipated application of the study findings (Morse, 1994a). Ethnography is one of the well respected methodologies for qualitative research in the social sciences. It has its roots in cultural anthropology and fieldwork at its heart. Classical ethnographers such as Malinowski studied communities or cultures in order to discover how people defined their world (Brunt, 1999). These early ethnographers then integrated the details of their discoveries to achieve an understanding of life in a particular social group (Hammersley & Atkins, 2007; Murphy, 2005).

Madeleine Leininger is credited with introducing ethnography to nursing as a qualitative research method to advance the science. She challenged nurses to think about how health care beliefs and practices impact on health and how to ensure that culturally appropriate care is delivered (Leininger, 1997). Many nurse researchers have since used ethnography to examine phenomenon important to the development of nursing knowledge (Boyle, 1994).

Reflections on Liberia

Four months into the nursing doctoral program at the University of Arizona, I found myself in Liberia, West Africa faced with some of the most horrendous social and health situations I had ever witnessed in my life. The purpose of the trip was to conduct an assessment of maternal-child health services in Liberia. During that first trip, 11 rural communities in the counties of Bong and Nimba were visited covering 157 catchment communities with a total population of approximately 125,000 residents.

Rural clinics staffed by one or two registered nurses or certified midwives were providing care for 9-28 catchment communities with populations ranging from 2,000-22,000. Some of these catchment communities are several hours away from the clinic by foot. There is no public transportation. Roads from many of the villages are impassible during the rainy season. Clinics are often a 60-80 kilometer walk to the nearest paved road. Once at some of the clinics, it is often another 24 hour walk to the nearest hospital (Lori, 2006).

The major referral hospital in the area was looted by rebels during the war who carried away anything they thought could be sold while damaging and destroying everything else. Nurses and doctors were brutally murdered. One young man relayed the story of hiding from the rebels under dead bodies in the morgue.

During that first trip to the field, interviews were conducted by a team comprised of Liberian nurses, midwives, and myself. Clinic staff, traditional midwives attending home births and women who delivered at home with the assistance of a traditional midwife in the last six months were interviewed individually and in focus groups.

During long drives into the field with the nurses and midwives, many stories of life during the war were shared with me. I became aware of the horror and violence women in Liberia faced during the war. It became clear to me that these events could not be ignored when exploring the contributing factors to maternal mortality.

One of the Liberian women on the team had fled to Guinea during the violence. She was seven months pregnant when the rebels raided the hospital where she worked as a nurse. She walked for two days to the Guinea border with her three children. She and her family lived in a refugee camp in Guinea for two years. Her youngest child was born in the camp. Here was a highly educated woman by Liberian standards, a nurse with a bachelor's degree, forced to flee on foot to save herself and her children. Her struggle was common.

It was through these dialogues that I came to understand the need to direct my experiences toward situations as a participant of the research process. This research study was shaped by the socio-historical location as well as by the values and interests I bring to the process (Hammersley & Atkins, 2007). It was also through this process of listening to others that I understood the need to discover and co-construct meaning in a dialogic relationship, uncovering structures of oppression (Denzin, 2003).

I began to reflect on the injustices of civil war, especially to women and children. I also began to feel a moral obligation toward changing the conditions for women and children in Liberia and to reflect on the power and privilege we have in the "first world". I came to realize, as a researcher, I could use the skills and privileges available to me to

make accessible the voices and experiences of those whose stories would otherwise go unheard (Madison, 2005).

Each subsequent trip influenced the course of direction for my research. I could no longer ignore the hegemonic practices I was hearing about and witnessing. I became committed to developing a deeper understanding and connection with the struggles of Liberian women. My goal became clear - to participate in a shared research process. To work with Liberian women to help recover meaning to their lives following the senseless violence and brutality and perhaps in the process, move people to action.

Interpretive Methodology

Interpretive methodologies are qualitative, inductive approaches to research. It is often linked to Max Weber who advocated an approach of understanding and explanation in the human and social sciences (Crotty, 2003). Interpretive methodologies are often used to explore and describe the complexity of a particular everyday life experience. The methods locate the researcher as a participant, emphasizing the importance of reflexivity and the interactive nature of participant observation (Lowenberg, 1993). The importance of context as well as the co-construction of knowledge between participant and observer is central to interpretive methodology (Munhall, 2003). The defining characteristics of ethnography focus on the subjective meanings individuals assign to the conditions and events in their lives (Denzin & Lincoln, 2005). The researcher can no longer be written out of the text in this interpretive process. She or he must acknowledge their own values and bias and how they contribute to the decisions made in the research process. Unlike the positivist paradigm, where research procedures can be standardized, ethnography

connects the researcher and participants in ways that expose the more fluid constructs of values and beliefs of each. It is therefore critical the researcher self-reflect as well as monitor how his or her personal constructs of the world mold the research process and the choices made during data collection and analysis (Hardcastle, Usher & Holms, 2006). Interpretive ethnography strips away the imperialism of early ethnographic methods, abandoning the concept of observer and “other”. The researcher is no longer a neutral spectator (Denzin, 1997). Knowing becomes more complicated. Interpretive research is “guided by the researcher’s set of beliefs and feelings about the world and how it should be understood and studied” (Denzin & Lincoln, p. 22).

Critical Ethnography

Critical ethnography is a reflective process that defies the limitations of positivism and post-positivism. It challenges the early ideals of ethnography as an objective, neutral, value-free account of a culture. Instead it advocates a more humanistic approach to objectivity by acknowledging and identifying how life experiences and identities of the researcher affect the setting and the final product (Denzin, 1999; Murphy, 2005). It moves beyond an interpretive boundary to include considerations of the social and political foundations within a society (Bruni, 1995).

Critical ethnographers speak “to an audience on behalf of their subjects as a means of empowering them by giving more authority to (their) voice” (Thomas, 1993, p. 4). Critical ethnography has been defined as having a political purpose with emancipatory goals (Denzin, 1999). It allows the researcher to shift the focus from individuals or

groups to examine the social complexities within a given society (Cook, 2005) adding historical as well as structural perspectives (Simon & Dippo, 1986).

Critical ethnography addresses processes of unfairness or injustice in a particular lived domain with a moral obligation to change oppressive conditions (Madison, 2005; Thomas, 1993). It involves exploration of how class, gender, power, economic policies, and socio-historical interactions impact marginalized segments of society. Critical ethnography becomes a conduit for the voiceless with its overriding goal to challenge established social constructs, freeing individuals from domination and oppression (Anderson, 1989). It becomes a starting point for social transformation.

Ethnography takes place in naturalistic settings. In ethnography the researcher is the learner with a goal to understand why (Cook, 2005). Collaboration with participants is central to ethnography. Developing intimate, trusting relationships is paramount to the research process. Research carries with it power differences and status for the researcher. Power relationships inherent to the process must be acknowledged in critical ethnography. Mutual dialogue is fundamental to this research process. Critical ethnographers strive for a collaborative, less hierarchical relationship with participants.

There is an ethical obligation with critical ethnography to empower participants. This can be accomplished by encouraging them to become part of the research process. Subjects, in the traditional sense of the word, become co-participants. Examples of this include eliciting input regarding direction of the research, encouraging participation in interpretation of the data, and requesting review and feedback on transcripts from co-participants.

A challenge of conducting critical research is the concept of reflexivity. As researchers are part of the world they study in ethnography, the issue of reflexivity becomes central to any discussion of ethnographic methods (Anderson, 1989; Hammersley & Atkinson, 2007). Reflexivity calls for a continual re-examination of how the researcher affects the research process and outcome as well as whether or not one is truly representing the reality of the participants.

Procedure for Protection of Human Subjects

Human subjects approval for this study was obtained from the University of Arizona Institutional Review Board (IRB). Prior to submitting to the campus wide IRB all human subjects material was sent to the College of Nursing Departmental Review Committee for review and approval. Human subject approval was obtained prior to the beginning of the research (Appendix B). Additionally, written approval was received from the medical director of Phebe Hospital in Liberia (Appendix C) as well as from the administrative person who oversees the Africare clinics (Appendix D) that are described in the setting for the study.

Sample and Setting

Setting

Liberia is located in the tropical rainforest on the west coast of Africa. Its population is approximately 3.5 million. The capital city, Monrovia, lies on the Atlantic Ocean at approximately 6° latitude north of the equator. Phebe Hospital is approximately a four to five hour drive northeast of Monrovia (Appendix E). It is located in rural Bong County and is considered a referral hospital for Bong and surrounding counties. A

housing compound is built around the hospital which provides homes for hospital staff and their families. The hospital has a bed capacity of 150 with approximately one-third of these beds devoted to obstetrics and gynecology. In 2006, a total of 65,365 patients were admitted to Phebe Hospital and 10,232 patients were seen in the Emergency Room (ECLA, 2006). From May 2006-April 2007, 1,108 births were recorded in the delivery log on the labor and delivery unit, 34 maternal deaths, and 61 cases of severe maternal morbidity including ruptured uterus, postpartum hemorrhage, and pre-eclampsia (Lori, 2007).

Sixteen rural health clinics in Bong county with a catchment population of approximately 600,000 residents also are a portion of the setting for this study. This county experienced some of the heaviest fighting and destruction during the most recent civil war when Charles Taylor led his rebel army into Liberia from the Ivory Coast to overthrow the government of Samuel Doe (Swiss, et al, 1998). The rural clinics are managed by Africare, a U.S. based non-government organization (NGO) and staffed by Liberian nurses and certified midwives. These clinics utilize Phebe Hospital as the referral hospital for emergency obstetric care. Table 2 provides a selected overview of demographic data for six Africare clinics included in the sample setting from Bong County.

TABLE 2: Select Demographic Data from Six Africare Clinics Located in Bong County

Bong County Clinics	Number of Catchment Communities	Approximate Population of Catchment Area	Distance To Phebe Referral Hospital
Salala	16	22,996	85 km away. Approximately one hour by car to Phebe Hospital.
Gbarmla	28	2,000	5 hour walk to the paved road plus 25 km of paved road.
Fenutoli	22	15,800	8-9 hour walk (17.5 mi.) to paved road plus 30 km of paved road.
Gbonota	10 (+ 6 from neighboring county)	6,429	7-8 hour walk (21 miles). Occasionally a car is available for 2,500 Liberian Dollars (LD*) (*50LD=1USD)
Gbalatuah	19	8,014	2 hour walk to Medicin du Monde Clinic, then one hour by car.
Zebay	18	11,900	3 hour walk to the paved road plus one-half hour drive (48 km). Cars charge 4000LD to drive to Phebe Hospital.

All clinics provide routine maternal child health care including antenatal care, labor and delivery support, postpartum care, immunizations, diagnosis and treatment of sexually transmitted infections, treatment of primary care conditions such as malaria, gastrointestinal disorders, fever, sepsis, and newborn care. They do not provide any specialized care, surgical services or advanced diagnostic services. They are typically staffed by one registered nurse and one certified midwife or licensed practical nurse. Additionally, each clinic has its own pharmacy and may have a small number of beds available for patients who need to remain at the clinic for observation.

Access to the Setting

Initial access to the setting was gained through pre-field work by the researcher over a two year period in Liberia in conjunction with the American College of Nurse-Midwives (ACNM) and Africare with funding from the United States Aid for International Development (USAID). A site authorization letter from both the hospital administrator and the administrator of the clinics was obtained (Appendixes C and D). The sites were selected because of the long term affiliations and partnerships built over the past two years. My ability to gain access to this setting was established in this earlier work. Negotiating access requires intra- and inter-personal resources and strategies such as establishing relationships and a working presence in a community (Hammersley & Atkinson, 2007). Seven months of in-country work over two years as lead consultant on a project to increase capacity and strengthen reproductive services at both the community and hospital level helped in the preparation for this study. I participated in community work in the form of educational trainings for clinic and hospital personnel as well as traditional birth attendants and community members from 2006-2007. The research questions for this study developed directly out of this work with input from community members and leaders. In the two years prior to this study, relationships with key community leaders were solidified. Gatekeepers at government, hospital, clinic, and community level were identified and included in the process. Research ideas were discussed with community leaders and members as gaps in knowledge were identified.

Sampling Plan

The purpose of this study was to understand the socio-political and cultural context of childbirth in Liberia including practices, beliefs and traditions that influence maternal health, illness and death. In this study, a wide sample of individuals with experience and/or knowledge about the phenomena, either directly or indirectly were interviewed. The sample for this study was composed of individuals associated or familiar with ten cases of severe morbidity and 8 cases of maternal mortality from Phebe Hospital and the outlying rural clinics managed by Africare.

The following steps outline the sampling plan procedure: (1) The PI attended staff meetings for nurses on the labor and delivery unit and the emergency department, as well as meetings of the Africare clinic staff to describe the study and recruitment procedures for possible participation in the study. Nurses in the hospital and clinics then let potential participants (based on inclusion criteria) know in English or Kpelle about the study and how to contact the researcher using the Introductory Information Script (Appendix F and G). Potential participants self-referred from the clinics and hospital. The PI did not inform hospital staff about who did or did not participate in the study; (2) For each participant who called about the study or was called, the translator/cultural broker or PI reviewed and confirmed that the participant met the inclusion criteria. If the potential participant met the inclusion criteria, the translator/cultural broker or the PI used a recruitment script (in Kpelle or English) to verbally describe the project to the potential participant (Appendix H and I).

Participants included women, family members and community members. All were Liberian, spoke Kpelle or English and were age 18 or older. The following definitions were used to describe the population recruited for this study:

Definition of Terms

- *Postpartum Women*: Adult women who have experienced a severe complication related to pregnancy or childbirth in the past three months.
- *Family Members*: Adults who are relatives of women who have died during a pregnancy or shortly after childbirth or experienced a severe pregnancy related complication.
- *Community Members*: Adult community members and health care providers including indigenous healers and traditional birth attendants, translator/culture broker, physicians, nurses, certified midwives and those with knowledge of the contextual factors in the area of interest.
- *Maternal Mortality*: The International Classification of Diseases, 10th edition (ICD-10) definition of maternal mortality was used for the purpose of this study. It states “the death of a woman while pregnant or within 42 days (or one year for late maternal death) of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes” (WHO, 1992).
- *Severe Morbidity*: Any pregnant or recently delivered woman (within 6 weeks after termination of pregnancy or delivery) who experiences complications that immediately threaten her survival but do not lead to her death; who arrived at the hospital or clinic in a

critical condition or developed a critical complication after admission (Fillippi et al., 2005; WHO, 2004). These included five main diagnostic areas:

- Hemorrhage leading to shock, emergency hysterectomy and/or recommended blood transfusion
- Hypertensive diseases of pregnancy including eclampsia and severe pre-eclampsia
- Dystocia resulting in uterine rupture
- Infections with fever or a clear source of infection and clinical signs of shock
- Severe anemia with hemoglobin levels $\leq 6\text{g/dl}$

Inclusion Criteria for Postpartum Women

- Any postpartum woman who suffered a severe childbirth related complication in the past three months
- Over the age of 18 years old
- Willing and able to share experiences related to severe morbidity resulting from a pregnancy or childbirth complication
- Speaks English or Kpelle language

Inclusion Criteria for Family Members

- Adult men and women who are relatives of a woman who has died during pregnancy or shortly after childbirth or experienced a severe pregnancy complication
- Over the age of 18 years old

- Willing and able to share their own experiences and understandings related to maternal morbidity and mortality
- Speaks English or Kpelle language

Inclusion Criteria for Community Members

- Community members, and health care providers including indigenous healers and traditional birth attendants, translator/culture broker, physicians, nurses, certified midwives and those with knowledge of the contextual factors in the area of interest
- Over the age of 18 years old
- Willing and able to share their own experiences and understandings related to maternal morbidity and mortality in Liberia
- Speaks English or Kpelle language

As this study was conducted to provide an understanding of childbirth and maternal illness and death through the lens of women, communities, and families, purposive sampling was highly appropriate. Purposive sampling is used when participants are chosen based on the purpose of the study. Participants were chosen based on their experiences with maternal morbidity and mortality and their ability to reflect on the questions asked, thus providing rich data.

Secondary sampling strategies, including chain referral sampling, were also used to identify members of the population of interest who could speak to the events surrounding a pregnancy related morbidity or maternal mortality. According to Penrod, Preston, Cain & Starks (2003) chain referral sampling is useful for inquiries into sensitive

topics that involve hard to reach or hidden populations. According to the authors, this sampling technique is “appropriate for studies that support the use of multiple sources of participants in order to maximize variation within social networks” (Penrod, Preston, Cain & Starks, 2003, p. 106). Chain referral sampling relies on participant referrals to others they know who have experienced the phenomena of interest, in this case maternal morbidity or mortality. Selected participants, knowledgeable persons in the community and others were requested to assist in referrals to potential participants based on substantive as well as design considerations. In the event of a maternal death it was necessary to identify those individuals who could relate the events surrounding the woman’s death. Chain referral as a sampling technique is especially useful when only a few individuals possess the information sought.

Selection and Description of Translator/Cultural Broker

One nurse was hired as translator/cultural broker for all individual interviews. This nurse was known to me from previous work in Liberia. She is fluent in verbal and written Kpelle dialect and culture as well as in English. No certified translation services are available in Liberia; therefore, this nurse was included as a subject in the broader study. As a participant, she provided useful information to understand childbirth and maternal illness and death. The nurse acting as translator/cultural broker was not responsible for providing patient care to women at the hospital or community level nor was she involved in recruiting participants for the study.

Training of Translator

As the principle investigator, prior to the data collection process, I met with the translator/cultural broker to discuss the research, the intent of the questions, and the overall purpose of the research. She was asked to read the list of questions from the semi-structured interview guide. Time was allocated to go over the intent of each of the questions individually and discuss how the questions might be posed using prompts or probes. Additionally, we discussed strategies and interview skills such as establishing rapport, active listening and building trust with participants.

Recruitment

All women, family members and community members who met the inclusion criteria were identified by staff nurses at the hospital and clinics or by word of mouth and the chain referral effect through individual communities. I attended one of the monthly meetings for hospital staff on the labor and delivery unit and the emergency department, as well as met with Africare clinic staff to describe the study and recruitment procedures for possible participation in the study. Nurses in the hospital and clinics then let potential participants know about the study and how to contact the researcher or translator/cultural broker. A recruitment script in English and Kpelle was used by the researcher and translator/cultural broker to assure consistent information was being shared with potential participants (Appendixes H and I). Once potential participants were identified and contacted by the researcher or translator/cultural broker, an initial meeting was arranged in a private space chosen by the participant. This meeting was used to discuss the purpose of the study and the terms of the research relationship. If the individual agreed to

participate in the study, consent was obtained from the potential participant using the appropriate English or Kpelle language informed consent form (Appendixes J and K). Written informed consent was obtained from those participants who were literate. For those unable to read, the informed consent was read by the PI or the translator/cultural broker to the participant in their preferred language. If the individual agreed to participate, the first interview was scheduled at that time.

Informed Consent

Informed consent was obtained using the following process: 1) for those potential participants who contacted the PI and/or translator/cultural broker, a 1-hour appointment was scheduled in a place that provided privacy and was convenient for the participant; 2) at the scheduled meeting, the consent form, available in both English and Kpelle languages, (Appendix J and K) was read by the PI or the translator/cultural broker to the participant in their preferred language. The potential participant was encouraged to ask any questions during this time. After completing the presentation of the consent form, the potential participant was asked what questions or concerns they had about the study. Each of their questions was answered by the PI or the translator/cultural broker. The potential participant was encouraged to discuss the study with their family members and friends during the next seven days; 3) after seven days the PI or the translator/cultural broker contacted the potential participant and asked about their final decision to participate in the study. If the potential participants stated they were interested in participating in the study, the PI and/or the translator/cultural broker scheduled a time to witness their

signatures or marks on the consent form and provided them with a copy of the signed consent form.

Participants were informed they could decline to answer any question or stop talking at any time they wished during the interview process for any reason. They were also informed they could request the audio-recorder be turned off at any time.

Data Management

Each participant was assigned a pseudonym. A participant log (the only link between identifying information and code numbers) was kept in one locked file cabinet and all data (demographic questionnaire, audiotapes, transcripts, and memos) were kept in a separate locked file cabinet in the designated work area assigned to the researcher in Liberia. Only the researcher had access to the files. Once the data were translated, checked for accuracy and analyzed, the code book that linked the participant's names with the pseudonyms was destroyed. Once the audiotapes were translated and checked for accuracy they were destroyed.

The Collaborative Institutional Training Initiative, human subjects training, established by the University of Arizona was completed by the student researcher. Issues regarding confidentiality were reinforced prior to each interview with the translator/cultural broker.

International Research with Vulnerable Populations

Research is done around the globe on health related topics. Research has been conducted on maternal morbidity and mortality in many countries in Africa. Guidelines for ethical research across international and culturally diverse communities are published

by many sources including the International Confederation of Midwives (2006). As a midwife, I am bound by this code to assure no harm is caused as a result of my research. International research studies must adhere to recognized Codes of Ethics such as the Nuremberg Code, the Declaration of Helsinki, and the Belmont Report (Cho & Rose, 2007). Language and cultural sensitivities must be addressed as well as the inclusion of appropriate community or tribal leaders. Much of my understanding of life in Liberia has been gained firsthand during seven months of pre-fieldwork in the country. My understanding of vulnerability and the health status of women in Liberia has shaped my research plan. Each subsequent trip to Liberia has influenced the course of direction for my proposed research. During my trips I have consulted with community leaders and stake holders who have provided me with important insights about the local customs, norms, and laws. Applying knowledge I have gained of vulnerable populations and the health status of women in Liberia has directed my research plan.

Data Collection

Hammersley & Atkinson (2007) describe data collection in ethnography as “watching what happens, listening to what is said, and/or asking questions through informal and formal interviews, collecting documents and artifacts – in fact, gathering whatever data are available to throw light on the issues that are the emerging focus of inquiry” (Hammersley & Atkinson, 2007, p. 3). Data collection for this study included a demographic questionnaire, in-depth semi-structured interviews and participant observation including field notes. Documents and artifacts such as newspapers and posters also were examined and used when relevant. Data collection in ethnographic

studies requires collecting data in natural settings from a variety of data sources and flexibility in sampling strategies as the research process progresses to penetrate layers of cultural knowledge.

Demographic Questionnaire

A demographic questionnaire, in English or Kpelle, was filled out on each woman who died or suffered a severe life threatening complication during pregnancy or childbirth (Appendix L and M) as well as each of the participants (Appendix N and O). If the woman suffered a severe morbidity and agreed to be interviewed, then the questions were addressed directly to her by the researcher or translator/culture broker. If a maternal mortality occurred, her next of kin or whoever responded to the interview questions were asked for the deceased's demographic information.

Participant Observation

Participant observation is a key method for collecting data on how people move and interact with one another and their physical environment. It helps to capture the context of the research setting and provides insight into interaction between individuals and groups (Munhall, 2003). Participant-observation is used to understand and interpret cultural behavior in ethnographic research. Observations are recorded and reviewed by the researcher as he or she is immersed in the field. Observations were made during every encounter and recorded as field notes as well as documenting observations during individual interviews. Additionally, I participated in many community activities as well as activities around the hospital and out-patient clinics while living in Liberia during the data collection phase.

Participant observation not only provides an understanding of the cultural context under study but also has the potential to change the positionality of the researcher (Madison, 2005). A continuum from complete-observer to complete-participant has been described in the literature (Junker, as cited in Munhall, 2001). Where the researcher is situated on the continuum is often very fluid. Movement on the continuum is influenced by many aspects of the research design and process. It is imperative for the researcher to document and consider how these changes impact data collection and analysis over the course of the project.

In this study, the observer as researcher role was assumed for data collection informing the participants at the outset of the intention of the study (Munhall, 2001). A variety of activities including observing at the clinics, in the communities and in and around the hospital provided an opportunity to observe pregnant women interacting with health care providers as well as in their activities of daily living.

Field Notes

Meticulous field notes were kept during the entire participant observation process as they are a mainstay of ethnographic research. There are a number of guides to compiling accurate field notes (Emerson, Fretz & Shaw, 1995; Hammersley & Atkinson, 2007, Munhall, 2003; Spradley, 1979; Wilson, 1989). Field notes were taken during participant observation when appropriate or as soon as possible after an observed action. Additionally, a reflective diary was kept as suggested by Munhall (2003) to aid in reflections of life experiences that had the potential to influence the research process. Included in the diary were thoughts about the field situation, structural and historical

forces that informed the social constructs under examination as well my ideological biases (Anderson, 1989).

Wilson (1989) recommends four types of field notes be kept including: 1) personal notes (PN) to document the researcher's feelings, biases and perceptions of things such as those described above by Munhall (2003); 2) methodological notes (MN) to reflect on the research process and techniques with the potential to shape future direction of the research as it unfolds as well as retrace the development of the research design, therefore acting as an audit trail; 3) observational notes (ON) which are the "who, what, when, where and how" of the field research; and, 4) theoretical notes (TN) which contribute to theoretical development and are derived from analysis and interpretation of observational notes. Hammersley & Atkinson (2007) refer to this last type as analytic notes or memos which are "the essence of reflexive ethnography" (Hammersley & Atkinson, 2007, p. 151). One spiral bound notebook was kept with me at all times for field notes. Notes were written in the left hand column and labeled in the right column using the recommended four types or categories of PN, MN, ON or TN from Wilson (1989).

Interviews

Interviews help us to understand each other. Fontana & Frey (2007) describe "empathetic interviewing" as an active technique that promotes a partnership between the researcher and the participant. A non-threatening, confidential environment was provided for all interviews. Participants were assured the sole purpose of the research was to understand and not appropriate blame because of the sensitive nature of the context.

Semi-structured, in-depth, interviews were conducted in the participant's choice of Kpelle or English language using the interview guide (Appendix P, Q, R, S, T and U). Semi-structured interviews allowed participants to guide various aspects of the interview illuminating their own perspective on the topic under study (Morse, 1994b). The translator/culture broker was present at every interview regardless of the participant's primary language. All interviews were audio-taped and transcribed into English. Simultaneous observational field notes were taken during the interview by the researcher when appropriate.

Semi-structured, in-depth interviews were used as the basis for data collection. Using the elements described by Spradley (1979) of explicit purpose, ethnographic explanations, and ethnographic questions, the researcher repeatedly offered explanations of the research study with each interview. This included general statements about the project as well as the explicit purpose of the study. Participants were given explanations for the recording of responses as well as the reason for writing things down. They were also given an explanation of the types of questions to be asked such as the three main types of question; descriptive questions which asked the participant to describe something, structural questions which allowed the researcher to discover information about domains of cultural knowledge, and contrast questions which allowed meaning to emerge from the various forms of native language (Spradley, 1979).

Procedures for Interview Data Collection

The first interview with postpartum women and family members was developed to get to know the participant and develop a trusting relationship. The demographic

questionnaire was filled out during the first interview. Initial questions were open ended to allow flexibility and give the participants the opportunity to tell their story. These included general questions about the woman's pregnancy and practices and traditions surrounding pregnancy as well as her experience with this pregnancy. The questions focused on gathering information about when the participant first noticed a problem and beliefs surrounding the reasons for problems during pregnancy. The second interview focused on the context for deciding to seek care and beliefs related to survival as well as the interaction with the health care system.

Only one and occasionally two interviews were conducted with community members. Adult community members and health care providers including indigenous healers and traditional birth attendants, translator/culture broker, physicians, nurses, certified midwives and those with knowledge of the contextual factors in the area of maternal morbidity and mortality made up this group.

Translation and Interpretation

Liberia is classified as an "Anglophone" country. Despite its 15 active tribal languages, the official language of the country is English. Kpelle is the widest spread tribal language of Liberia. It is spoken by about 750,000 people, or one-third of the total population. Kpelle belongs to the Mande branch of the Niger-Congo family of languages (World Languages, 2007). Many people in Liberia speak both English and Kpelle.

Recruitment scripts, disclosure forms, demographic questionnaires, and interview guides were translated into Kpelle using Brislin's model for translating and back-translation (Brislin, 1970; Hilton & Skrutkowski, 2002; McDermott & Palchanes, 1994).

Rigorous documentation of the translation procedure was done to ensure loyalty of meaning and semantic equivalence (Hilton & Skrutkowski). The translation was done with bilingual persons in Liberia. These translations took place during a scheduled trip to Liberia in February 2008, prior to data collection.

Working as a team, the translator / cultural broker and I listened to all the original tapes of interviews in the Kpelle language. The interviews were translated by the translator/cultural broker into English and transcribed by me during time spent in Liberia. These transcripts were then checked and back-translated from English to Kpelle by a transcriptionist who is a native Kpelle speaker as well as an English speaker. The translations were then reviewed for inconsistencies and to ensure accuracy by the translator/cultural broker. I personally transcribed all English language interviews while listening to the original tapes.

Data Analysis

According to Denzin (1997) the many sounds and meanings of voice come together in the written text where original voices, their inscriptions or transcribed texts and the writer's interpretations become a montage. "The issue of voice leads into the form, nature, and content of the account" (Olesen, 2005, p. 253). In order to create new understanding and knowledge it is the obligation of the researcher to bring forth those voices that have not been heard. This is perhaps the biggest challenge faced in critical research. My views were challenged by the voices of the participants. These challenges were cause for examination and self-reflection. Time was allotted in the research process for this self-reflection to take place.

Construction of meanings were negotiated during the research process rather than imposed by the researcher-observer. Participants helped to shape emerging analysis through continued social discourse. As participants became aware of sociopolitical factors affecting their lives, they often became empowered. They frequently played an important role in the application of findings back into their own context and the broader environment (Cook, 2005). Development of voice in this research study was an iterative process that was continually developing. Use of “thick” descriptions provided context to the meanings derived between researcher and participants. These descriptions conveyed the voices of the participants.

Allowing participant voices to emerge and be reflected in the data analysis was central to this research. In relation to the researcher’s voice, several strategies are described by Denzin & Lincoln (2005). The strategies include the researcher’s authoritative voice, which separates the researcher and the narrator’s voice; the researcher’s supportive voice, which pushes the narrator’s voice into the spotlight; and the researcher’s interactive voice, which displays inter-subjectivity between the researcher’s voice and the voice of the narrator. Each strategy was used at various times during the data analysis. This is an iterative process that is not a distinct stage of the research but rather a constant interplay between data and ideas throughout the research process (Hammersley & Atkinson, 2007).

It is important to give voice to those persons who have been marginalized. At some point voice and reflexivity blend into narrative. Representing someone else’s voice is a complicated undertaking (Madison, 2005). The approach for this study used the

researcher's interactive voice. Using this technique, the researcher examines his or her own voice through the "refracted medium of narrators' voices" (Denzin & Lincoln, 2005, p. 666). In other words, the researcher's voice is heard through reflection on his or her own experiences with participants. It is their voice that is central to the narrative yet as a researcher one is inseparable from the process.

The data analysis used an iterative process with simultaneous data collection and analysis to generate an interpretive theory of maternal mortality and morbidity in Liberia. Data from all sources including demographic questionnaires, participant observation, field notes, and individual interviews with participants, as well as archival data and other supplementary sources were analyzed to inductively derive patterns or themes from the data (Munhall, 2001). Data collection and analysis occurred simultaneously. After translation of the interviews was satisfactorily completed, the interview data was read several times by the researcher to become familiar with the data. The Ethnograph©, version 6.0, was used to assist with data storage and management including development of data files, codebooks and family trees; search and retrieval by codes and family; and memoing to assist in analytic writing (Qualis Research, 2008).

Data for this study were in the form of transcribed interviews from verbatim recordings. Data were coded and grouped into categories to facilitate abstraction and conceptual analysis. This process involved identifying units or segments of data — groupings of words, sentences, or even paragraphs and assigning a label or "code word" that described the meaning and/or content. As each unit of data was assigned, each successive unit was compared with previously identified units. This process continued

until all data in the interview were assigned a code word. A code book was developed simultaneously that contained all code words and their definitions (Appendix V).

Connections were made between various codes by reading and rereading transcripts and listening to the tapes repeatedly. All code words were examined and grouped into more abstract categories. Categories were then compared and clustered by re-conceptualizing them into more abstract domains of meaning, labeled as themes. I then looked for relationships between themes to generate an overarching theme and interpretive theory.

Throughout the stages of data analysis, numerous discussions with the qualitative methods expert and dissertation advisor, Dr. Joyceen S. Boyle, occurred on a regular basis. Transcripts were reviewed to verify the interpretations and ideas. Code checking occurred by reading a number of coded transcripts as well as having Dr. Boyle review my codebook as data analysis evolved. She also reviewed and made suggestions as conceptual categories developed from the data codes.

Participant observation data were analyzed initially by immersion in the data of every day research activities. These data were also compared to interview data that had been coded and categorized to contextualize the themes and concepts leading to theory development. The constant reading and re-reading of participant observation data led to changes and adjustments in methodological approaches as well as theoretical refinement throughout the research process.

According to Hammersley & Atkinson (2007) it is necessary for the researcher to know the data through detailed and repeated readings. Using emergent concepts, themes,

and patterns I began to draw out an interpretive theory of maternal mortality and morbidity in Liberia, West Africa that provides an understanding of the larger social and cultural context of childbirth and childbirth related practices, beliefs, and traditions. Additionally, simple descriptive statistics were used to analyze the demographic data of the participants in this study. Frequencies, means, modes and percentages were the statistics employed in this process.

Maintaining Rigor in Qualitative Research

The rigor of qualitative research has often been challenged by the positivist paradigm. Establishing rigor in qualitative research maximizes the reliability and validity of a study and generates confidence in our results (Sandelowski & Barrorso, 2003). Trustworthiness is the credibility and validity of qualitative research. It is important in establishing the quality of a qualitative research study. Trustworthiness is a continuous, overlapping process of establishing the truth that starts prior to entering the field. Lincoln and Guba's (1985) four criteria for establishing trustworthiness; credibility, dependability, confirmability, and transferability were used to guide this study.

Credibility

Credibility refers to the ability to reconstruct from the data what is credible to the participants. The techniques recommended for credibility include prolonged engagement, peer debriefing, member checking, and the use of multiple approaches to data collection.

Prolonged engagement is recommended by many authors as central to ethnography as well as to the establishment of trustworthiness (Denzin & Lincoln, 2005; Hammersley & Atkinson, 2007; Thomas, 1993). Only after prolonged time in the field

can one develop an understanding of the culture and the context, build trust and begin to detect distortions in the data (Lincoln & Guba, 1985). Credibility has been initiated through visits during the past two years with four trips to Liberia from 2006-2007. A total of seven months was spent in Liberia developing partnerships, learning the culture, and building relationships with the people of Liberia prior to data collection. Developing these relationships and understanding of the culture informed the research questions.

Peer debriefing involves discussion and exploration of specific aspects of the inquiry with a disinterested second party (Lincoln & Guba, 1985). This is recommended to ensure honesty, identify biases, and provide an opportunity to develop next steps in the emerging design of a project. It allows the researcher to bounce ideas off a colleague. It differs from peer review which will be discussed under dependability. Peer debriefing was done with the translator/cultural broker following each interview session. I was also in constant dialogue with my Dissertation Advisor via e-mail. Transcripts of interviews were sent to her via email so she could read and comment on them. She assisted me with reading of transcripts, discussion of coding, development of conceptual categories and generating themes.

Member checking also contributes to credibility through validation of the research findings by participants. Verification with as many participants as possible is recommended by Munhall (2001). This was done throughout the research process helping to define the emerging design in the field. Credibility is also established when presenting your research to the larger community and receiving validation of the findings. Initial findings from this study were presented to Phebe Hospital administrators and staff,

Africare administrators and clinicians, the Ministry of Health in Liberia as well as other stakeholders and interested parties upon completion of data collection.

Multiple data collection modes such as individual structured and semi-structured interviews, focus groups, record review, observations, and examination of artifacts increases credibility in a study. Data collection included participant observation, in-depth interviews, demographic questionnaires, and field notes. Supplementary sources of data were also included such as newspaper articles, historical accounts, nonfiction, and other types of documentation for background information.

Dependability

Dependability takes into account factors contributing to design induced change and instability (Lincoln & Guba, 1985). Careful attention to the process, analyzing methods as they are implemented and revisiting as needed, is central to the criterion of dependability. Reflexivity, establishing an audit trail, and expert peer review are some of the strategies that enhance dependability.

In ethnographic research, the researcher is the ‘human instrument’ used for data collection. Identifying one’s biases and assumptions is central to this process. A personal journal helped identify my own feelings, views, biases and perceptions. Asking different participants the same questions and observing for consistency in language and behavior enhanced dependability.

Establishing an audit trail allows others to follow the decisions made by the researcher. Documenting rationales for sampling strategies, analysis and dissemination of findings is included in the audit trail. Any time there is a decision made to change some

aspect of the study, a description of why as well as the thinking behind the change needs to be documented. This was accomplished through a record of theoretical, methodological, observational and personal notes. Diagramming links and relationships between categories, concepts and themes demonstrates how the interpretive theory developed. This process formed a decision trail that could be followed by an outside auditor in order to authenticate the process. Meticulous notes reflecting the process and rationale for changes were kept during the data collection and analysis phases. Finally, expert peer review from my dissertation advisor assisted in establishing this audit trail.

Confirmability

In order to corroborate or authenticate findings, confirmability is required. This is accomplished by extensive documentation of the process, somewhat similar to the audit trail described under dependability. Journaling, field notes, keeping recorded data and interview notes, notes on data synthesis and documenting decisions related to data analysis such as coding, themes and categories are all part of this process. Being confident the findings are grounded in the data further contributes to the trustworthiness of the data. All of these methods were employed during this research study in Liberia and in the data collection and analysis and writing that followed.

Transferability

Transferability is dependent on the degree of similarity within the context (Lincoln & Guba, 1985). There must be an understanding of not only the population under study, but also of the population to which one is inferring. Transferability therefore is left in the hands of the consumers of the study's findings. The task at hand for the

researcher is to be sure to provide ‘thick’ descriptions (Munhall, 2001) of the research process in order to provide an in-depth picture of time and context. There is also some judgment of the researcher at this point. My extensive clinical experience in maternal health will enhance the transferability of the findings as the clinical judgment I have developed after years of midwifery practice provides both the expertise and the intuitive ability to evaluate the research findings.

Summary

It is critical the researcher self-reflects as well as monitors how his or her personal constructs of the world mold the research process and the choices made during data collection and analysis (Hardcastle, Usher & Holms, 2006). The researcher must acknowledge his or her own values and bias and how they contribute to the decisions made in the research process. My biases come directly from my worldview. Health, in my view, is a complex state and not a linear model that one moves back and forth on from illness to well-being. Nursing, as a unique profession, works with each person for health through caring, advocacy, and interpersonal interactions. As a feminist I value the experiences of women and have placed them at the center of this research legitimizing their experiences and their voice. Women are not always valued in African cultures in the same way. Only by entering this world of human to human relationships will the voices of the previously silenced be heard.

Critical ethnography was the methodology chosen for this study to explore the underlying cultural practices, beliefs and traditions that impact maternal health in Liberia. This chapter described the setting and sample as well as outlined the procedural aspects

of recruitment, informed consent, data collection, management and analysis. The intent of this study was to provide an understanding of childbirth and maternal illness and death through the lens of women, families and communities in order to advance the science of nursing.

CHAPTER IV: STUDY CONTEXT AND PARTICIPANTS

A wide sample of individuals with experience and/or knowledge about this study's phenomena of interest, either directly or indirectly were interviewed. Individuals associated or familiar with 10 individual cases of severe maternal morbidity and eight cases of maternal mortality from Phebe Hospital and the outlying rural clinics managed by Africare made up the sample for this study. In addition, ten postpartum women suffering a severe maternal morbidity and 44 community and family members met inclusion criteria to make up the participant sample for a total of 54 participants. Key participants (women and/or family members) were interviewed two times by the investigator. Community members and health care providers with knowledge of the contextual factors in the area of interest were interviewed one to two times, depending on their availability and willingness to participate.

All participants lived in villages in Bong county. The population of the villages ranged from 60 to 60,000 occupants. Six of the eight maternal deaths that occurred during the time of the study occurred in villages less than 10 kilometers (6.2 miles) from a health clinic or hospital. Five of the ten women suffering a severe morbidity lived within 12 km (approximately 7.5 miles) of a health clinic or hospital. Fifty-four percent of the participants spoke English while forty-six percent spoke Kpelle or a combination of Kpelle and English.

Sample Demographics

Demographic data were collected from all participants and included a general participant descriptor data set. Information collected from postpartum women included:

age, village, district, population of village, tribe, gravidity, parity, number of living children, antenatal care provider by type, number of antenatal visits, birth attendant, distance from home to clinic, distance from home to hospital, religion, years of education, employment status and diagnosis. Information collected from family and community members included: age, village, district, population of village, tribe, distance from home to clinic, distance from home to hospital, number of household members, religion, years of education and relationship to the woman. Additionally, if family and community members were interviewed following a maternal mortality, information on the deceased woman was collected using the same categories as those listed above for postpartum women.

Postpartum Women

The ten postpartum women ranged in age from 18 to 26 years with an average age of 21.3 years. Size of household (number of people living in the home) ranged from 3 to 20 with an average of 8.7 people per home. The women's gravidity or number of pregnancies ranged from 1 to 10 and number of living children ranged from 0 to 8. The size of the village where the women resided ranged from 200 – 60,000 residents with two women unable to provide or estimate the number of persons living in their villages. All women belonged to the Kpelle tribe. Travel distance to the nearest clinic ranged from next door to eight hours by car. Distance by automobile to Phebe Hospital ranged from less than one hour to two and a half hours. Nine of the 10 women in the study were receiving antenatal care from a skilled attendant at either a rural clinic or hospital. Six of them planned to deliver with a skilled attendant at a clinic or hospital and four planned to

deliver with a traditional midwife in their home communities. All but one had made at least four antenatal visits, the recommended number of visits with a skilled provider in the developing world. Two women accessed multiple care providers for antenatal care. One woman sought care from both a black bagger (men and women who pose as health care professionals treating pregnant women as well as family and community members at the village level) and a traditional midwife and one sought care from a rural clinic, black bagger and pharmacy. Years of education ranged from zero to eight with the average number of years of formal education three years. Four women stated they worked on a farm, three were unemployed, one worked as a cook and one worked in a business. All stated they were a member of a Christian church. All women met the eligibility criteria with four women diagnosed with eclampsia, four with ruptured uterus, one with sepsis and one with postpartum hemorrhage requiring a transfusion. Table 3 provides an overview of select demographic data for the 10 postpartum women included in this study.

TABLE 3: Select Demographic Information: Postpartum Women Participants (n=10*)

	Mean	Range
Age	21.33	18-26 *1 unknown
Education (years completed)	3	0-8
Size of household	8.7	3-20
Gravidity (number of pregnancies)	2.9	1-10
Number of living children	1.8	0-8

*One participant did not know her age

Family and Community Members

The 44 family and community members ranged in age from 18-70 years ($X = 45.3$ years). Tribal affiliation was as follows: 30 Kpelle, 4 Bassa, 2 Gio, 2 Kissi, 1 Loma, 1 Gerbo, 1 Mano, 1 Gbandi, 1 Mandingo and 1 Vai (see Table 4). Kpelle is the predominant tribe in Bong county and the predominant tribal language spoken in Liberia. Twenty-six participants were community members and 18 were family members including husband, father, mother, mother-in-law, daughter, sister, aunt and brother-in-law of the postpartum or deceased women (Table 5). Employment varied with 12 farmers, 8 nurses, 8 certified midwives, 6 traditional midwives, 2 teachers, 1 blacksmith, 1 baker, 1 black bagger and 3 unemployed (Table 6). Size of household ranged from 1 to 30 ($X = 8.6$) with 10 participants unable to answer the question because of fluid living arrangements. Years of education ranged from 0-20 ($X = 7.5$). All except four participants stated they were a member of a Christian church.

TABLE 4: Tribal Affiliation of Community and Family Member Participants (n=44)

Tribal Affiliation	Number	Percentage
Kpelle	30	68%
Bassa	4	9%
Gio	2	5%
Kissi	2	5%
Loma	1	2%
Gerbo	1	2%
Mano	1	2%
Gbandi	1	2%
Mandingo	1	2%
Vai	1	2%

TABLE 5: Family and Community Members and Their Relationship to the Postpartum or Deceased Women in the Study (n=44)

Community & Family	Number	Percentage
Community Members	26	59%
Family Members	18	41%
➤ Husband	6	33%
➤ Mother	5	28%
➤ Father	2	11%
➤ Mother-in-law	1	6%
➤ Daughter	1	6%
➤ Sister	1	6%
➤ Aunt	1	6%
➤ Brother-in-law	1	6%

TABLE 6: Occupation of Community and Family Members (n=44)

Occupation	Number	Percentage
Farmer	12	27%
Nurse	8	18%
Certified Midwife	8	18%
Traditional Midwife	6	14%
Teacher	2	5%
Blacksmith	1	2%
Baker	1	2%
Black Bagger	1	2%
Unemployed	3	7%
Other	2	5%

Maternal Mortalities

Additionally, demographic information was collected from family members about the eight women who died that were included in the study. The eight women ranged in age from 21 to 37 years ($X = 25.1$ years). Each woman had been pregnant between one and nine times. Twenty-one children were left motherless by the deaths of these eight women (range 1 to 8 living children per woman). Their children ranged in age from newborn to 18 years. Six women belonged to the Kpelle tribe, one to the Mandingo tribe and one to the Bassa tribe. Distance to the nearest health clinic from the home of the deceased women ranged from 10 minutes to eight hours by car. Distance by automobile from each home to Phebe Hospital ranged from 30 minutes to four hours. The size of the villages where the women resided ranged in population from 60 to 60,000 with one family unable to estimate the number of persons living in that particular village. Seven of the eight women were receiving prenatal care at a health clinic from a skilled birth attendant. Three of the seven were seeking traditional care from a black bagger and a traditional midwife as well as from the formalized health system. One woman was receiving care only from a traditional midwife. Five of the women planned to deliver at home with a traditional midwife while three of the women planned to deliver in the clinic or hospital. Years of education ranged from 0 to 11 years with six of the eight women having no formal education at all ($X = 1.75$ years). Six women worked as farmers, one worked in a school and one had no work outside the home. Causes of death included: retained placenta (2); ruptured uterus (1); sepsis (2); malaria and hepatitis (1); internal

bleeding (1); and, lassa fever (1). Table 7 provides an overview of select demographic data for the 8 women who died included in this study.

TABLE 7: Select Demographic Information: Maternal Mortality (n=8)

Demographics	Mean	Range
Age	25.1	21-37
Education (years completed)	1.75	0-11
Size of household	11.25	4-29
Gravidity (number of pregnancies)	3.9	1-9
Number of living children	2.6	1-8

Summary

A total of 54 women, family members and community members provided the sample for this study to understand the socio-political and cultural context of childbirth in Liberia including practices, beliefs and traditions that influence maternal health, illness and death. Sampling within this study provided me with the opportunity to acquire insight and learn from various members of the community. The sample provided a diverse range of individuals, as described here, from which to gain a broad understanding on the topic of maternal morbidity and mortality in Liberia. A wide sample of individuals with experience and/or knowledge about the phenomena of interest, either directly or indirectly were interviewed providing a rich context for this study.

CHAPTER V: FINDINGS

This chapter presents analysis of data from interviews with 54 postpartum women, community and family members who met inclusion criteria for this study. It also draws on participant observation during seven months of in-country work over a two year period. Field notes were taken during participant observation experiences and are used to contextualize the findings. Data from all sources including demographic questionnaires, participant observation, field notes, and individual interviews with participants, as well as archival data and other supplementary sources were analyzed to inductively derive patterns and themes from the data (Munhall, 2001).

Using the analysis and coding processes described in Chapter 3, this chapter describes the iterative process used to develop an interpretive theory of maternal mortality and morbidity in Liberia. During analysis there was a constant flow between data and ideas (Hammersley & Atkinson, 2007) emerging from experiences in the field and analytic reflection on the data. The analytic induction is described from coding segments of data to development of the interpretive theory allowing the participants' voices to emerge.

Rigor of the data was maintained by multiple approaches to data collection, member checking with participants, development of an audit trail and expert peer review with my dissertation advisor. Interpretive theory was derived through a broad inductive process that abstracted codes into larger conceptual categories. Three themes were then inductively derived from these categories, ultimately forming the overarching cultural theme and creating the interpretive theory.

The purpose of this study was to understand the socio-political and cultural context of childbirth in Liberia including practices, beliefs and traditions that influence maternal health, illness and death. This study addressed the following two research questions:

1. How do Liberian women, family members and community members understand and describe maternal illness and death?
2. What are the political, social and cultural factors that influence the ways women seek care during pregnancy and childbirth?

Overarching Cultural Theme

The overarching cultural theme *Behind the House* links the relationships among codes, conceptual categories, and themes to provide an understanding of childbirth and maternal illness and death through the lens of women, families and communities. As the overarching cultural theme in this critical ethnography, *Behind the House* provides the basis for an evolving interpretive theory of maternal mortality and morbidity in Liberia. A cultural theme, as the term is used here, refers to a complex array of assertions, interpretations, beliefs and ideas that project an “insider’s view” of what is happening within a particular cultural scene (Spradley, 1979)

Three major themes support the overarching cultural theme *Behind the House*. They include: 1) *Secrecy Surrounding Pregnancy and Childbirth*; 2) *Power and Authority*; and 3) *Distrust of the Healthcare System*. Together they explain and define the broad overarching cultural theme and were used to develop an interpretive theory to describe the complexity of maternal illness and death in Liberia (Figure 1).

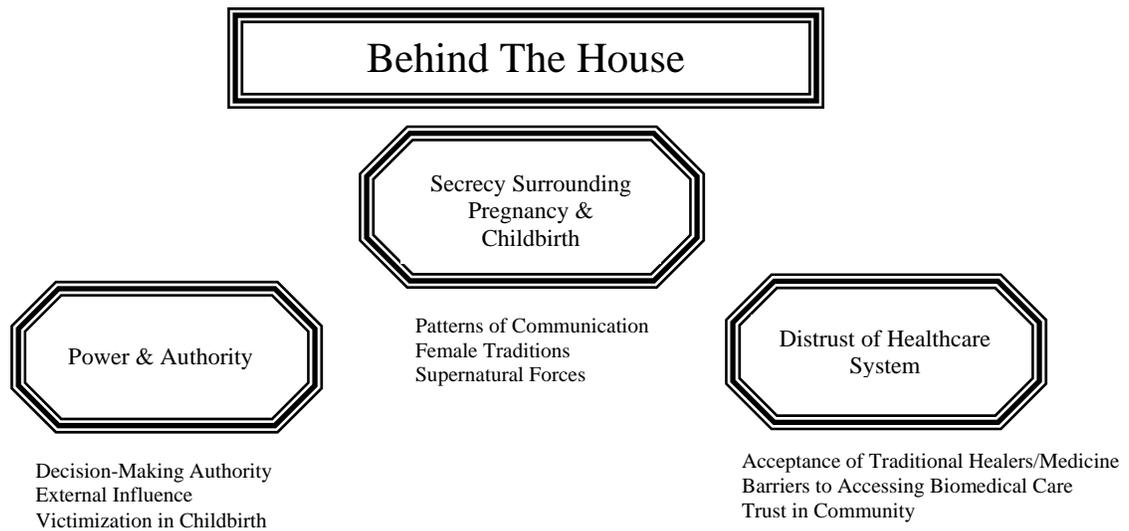


FIGURE 1: Conceptual Schema – themes and conceptual categories link and explain the overarching cultural theme and interpretive theory.

I will first describe how each theme was conceptualized by building inductively from each conceptual category and the linkages among them. Next, I will link the themes to support the overarching cultural theme *Behind the House*.

Major Theme – Secrecy Surrounding Pregnancy and Childbirth

Secrecy Surrounding Pregnancy and Childbirth is the first major theme inductively derived from the conceptual categories: 1) ‘Patterns of Communication’; 2) ‘Female Traditions’; and 3) ‘Supernatural Forces’. It is defined and expressed in the cultural context by hiding facts about pregnancy and childbirth or sickness related to pregnancy and childbirth from others. *Secrecy Surrounding Pregnancy and Childbirth* is a long established pattern of behavior for participants in this study and has been passed down through generations as the cultural norm.

The fostering of secrecy and hiding of information are notable features of Liberian culture (Ellis, 2007). Secrecy has its origins in traditional religious beliefs as well

as secret societies that exist throughout Liberia. These secret societies, also known as bush schools, are prevalent throughout Liberia and were attended by the majority of participants in this study. Part of Liberia's cultural heritage, secret societies known as Sande (for girls) and Poro (for boys) are attended by thousands of youngsters annually in rural Liberia (Ellis). Young girls and boys attend these bush schools separately for one month to one year depending on the location of the school. In less densely populated areas the bush school is held less often than in areas with a larger population. Each district or area (determined by geography and tribal affiliation) decides how long and when the school will be held. For girls, the Sande school is the place where they learn domestic skills such as how to cook, clean, care for their family and future husband as well as moral lessons such as respecting elders and religious teachings. It is also the place where female genital mutilation (FGM) takes place. Children usually attend these schools between the ages of 4 and 12 years old. The schools are controlled by elders or zoes in each area within a hierarchical system of each tribal area.

For young women in Liberia, *Secrecy Surrounding Pregnancy and Childbirth* implies there is potential danger to yourself and your unborn child in sharing information about your pregnancy with others. It is used to protect oneself from evil or spells cast by others who may wish to harm you in some way. Individuals internalize these norms of secrecy by not sharing information or knowledge about pregnancy and childbirth.

Conceptual Category: Patterns of Communication

'Patterns of Communication' is the first conceptual category contributing to the theme of *Secrecy Surrounding Pregnancy and Childbirth*. These patterns are reflected in

the way information is dispersed through a family or community. Information related to pregnancy is often provided by elders and guides a pregnant woman's action or conduct. When asked why pregnant women often do not come to the hospital or clinic for care, one community member replied, "It is their belief from their great grandmothers and grandfathers and also what they have been told by their family members and friends too." Women make choices for themselves and for their care during pregnancy based on what they are told by elders in their communities and families. Elders are held in high esteem and their word has traditional legitimacy for young pregnant women.

Secrecy is pervasive around childbirth from young women's knowledge of birth to who is involved in the actual delivery. One husband, whose wife died following the delivery of twins said, "My wife never told me she was going to have twins". When referring to what young women are told about childbirth, one nurse said:

'[They] don't tell them nothing at all. [They don't tell them they will] feel pain or where the child comes from. Some of them will even think they will vomit the child up. Yes. We had one in the labor room. When we wanted to do the vaginal exam she refused but we said the baby will come straight out of your vagina. She didn't believe. She thought the baby would come straight out of her mouth or somehow her body would open and the baby would come out.'

A member of the Reproductive Health Services at the Ministry of Health voiced her frustration, "Since it is a taboo for women to come out and talk about pregnancy and delivery and menstruation and other things, now we are trying to break that taboo."

Women often labor and give birth alone without help from others. The mother-in-law of one woman who died from a retained placenta and postpartum hemorrhage following the birth of her fourth baby described what had happened. She related the following:

‘When she got into labor she did not tell anyone. She went to the farm in the morning and only called me at the last minute and said “Spread the mat” and then she gave birth. When the traditional midwife arrived she did not think [the labor] was satisfactory and we should not waste time and [should] find a car. But there was no car here and we had to go to Palala on a motorbike to find a car...she was fighting and saying “I dying, I dying”. As soon as we reached the hospital she died.’

Another woman who was kept at home for five hours following delivery with a retained placenta also died. Her husband and other members of the community did not know she had delivered. The traditional midwife caring for the woman said, “Once a baby is born, it is our tradition, we don't announce it until the placenta has come out.”

Participants in this study described a lack of awareness regarding how to care for themselves during pregnancy as well as a lack of understanding regarding danger signs in pregnancy. In part, due to these ‘Patterns of Communication’ women are left with little or no information upon which to act if they experience difficulties during pregnancy or childbirth. These ‘Patterns of Communication’ contribute to the *Secrecy Surrounding Pregnancy and Childbirth* by encouraging women not to share important information related to childbearing.

Conceptual Category: Female Traditions

‘Female Traditions’ is the second conceptual category contributing to the major theme of *Secrecy Surrounding Pregnancy and Childbirth*. These ‘Female Traditions’ are the customs and beliefs handed down from one generation to the next that influence women’s behavior and actions. This category includes the rituals and taboos women talked about during the interviews as well as some that were witnessed during participant observation. Many of the ‘Female Traditions’ are learned in the bush schools when girls

gain knowledge about the role they will assume as young women and wives. The female zoes, or elders, teach the girls life skills as well as perform FGM as a rite of passage. The importance of young girls taking part in the bush school was highlighted by one participant who noted that, “When you go to those schools, then you are recognized in society.” Most people believe if children do not attend the bush school “they won’t know their culture.”

Many women talked about the bush schools with great fondness. There is dancing and games for young girls. They learn valuable life lessons such as cooking, cleaning and fishing as well as how to do handicrafts. They learn respect for their elders and how to be a good wife. They also learn that their husbands and older women are the ones who will make decisions for them. One woman related:

‘But in the bush school, people have always been saying that they train these girls to be submissive to their husband, to be submissive to older women, they are not allowed to make their own decision because they might make the wrong decision. These people (elders) will guide them through; these people are more exposed; these people have more experiences so they can make a better decision for them.’

Although several of the nurses in this study spoke to me about the elements of instruction girls receive from the elders in the bush schools, members are strictly forbidden to reveal details to non-members of the society. These nurses were members of the Sande society but perhaps because of the trusting relationship we developed over time or the influence of a western education in addition to their traditional beliefs, they were willing to share some information with me. One nurse who is still very active in the society told me, “When I joined in 1982, I was in the 8th year. Very small. I was 8 years old. I came out in 1983.” When I asked if it would be possible for me to visit a bush

school, my translator/cultural broker said, “If you are not a member you cannot go because they think you will want to know their secret.”

In addition to FGM, you can also identify a young girl or woman who has attended bush school by the markings on her neck, waist or arms. These markings, or ritual scarrings are made in distinctive patterns by cutting the skin with a sharp knife or instrument. The markings on many of the women were visible to me as I interacted with women in the communities and at the antenatal clinic and hospital. Many of the participants in this study had these distinctive markings.

‘Female Traditions’ influenced the core beliefs of participants in this study and have a profound impact on pregnancy and childbirth. It is a vital component in the development and maturation process for women in Liberia. These ‘Female Traditions’ contribute to the first major theme, *Secrecy Surrounding Pregnancy and Childbirth*. Initiation into the Sande society is an important social process for girls in Liberia. They are not considered part of the larger group in their village until they have attended the bush school and gone through the initiation of FGM. Undergoing FGM makes them a respected member of society. The procedure also affects their long-term health associated with childbearing. Women who have undergone FGM are at risk for multiple childbirth complications such as obstructed labor, uterine rupture due to the obstructed labor, formulation of fistula and incontinence (World Medical Association, 2003).

Girls are sworn to secrecy regarding the lessons they are taught during their time in the bush school. This secrecy is reinforced during pregnancy and childbirth by

superstitions and belief in supernatural forces as described in the next conceptual category.

Conceptual Category: Supernatural Forces

‘Supernatural Forces’ form the final conceptual category in the theme *Secrecy Surrounding Pregnancy and Childbirth*. ‘Supernatural Forces’ are described as some phenomena controlled or done by a force other than humans. For participants of this study it refers to the occult or forces beyond God, the church, humans or natural law. These ‘Supernatural Forces’ have their origin in the spiritual world.

Belief in witchcraft or magical powers underlies the *Secrecy Surrounding Pregnancy and Childbirth* for women in this study. There is a strong belief that certain members of society enjoy supernatural powers not afforded all humans. Anyone can have these powers and there is no way to identify who has them. The power may be passed down from a family member or a person may be part of a society that bestows supernatural powers to its members. These powers may be used to witch or bewitch another person, such as casting a spell on them to cause an illness or even death.

Women often leave their homes to live with their mother when they become pregnant, especially if the husband has more than one wife. One participant said, “So because of fear I try to go away and find some place to stay until I deliver so they (her husband and/or his other wives) don't bewitch me.” She thought the other wives would become jealous when they found out she was pregnant. She feared they would think she was more important to the husband than they were because of the pregnancy.

Another young woman who came to the hospital because of postpartum sepsis four days following her delivery said:

‘When you be in pain you start crying and [if you] announce it early some people can come there. If they don’t like you, they be against you and sign you in the form of witch you. They can tie the lappa (cloth covering used as a skirt in Liberia). If they tie the lappa you cannot deliver right away, you will be in pain for a long time and you will not deliver right away. Until they feel sorry they know you have suffered then they will go back and loosen the lappa and you will deliver. You cannot [tell many people when you are in labor].’

This was emphasized by a hospital nurse when she was asked if men believe in ‘Supernatural Forces’ as well as women. She described the pervasiveness of the belief in witchcraft by both men and women by saying:

‘Yes, everybody. Even as we work here all of us working here we know it and we believe it. Whether it actually happen or it don't, but people believe it. Sometime people die; sometime there is no natural death. Most deaths in Liberia people relate it to witch. Witchcraft. They witch the person. The person did not die by themselves. The clear fact so everybody believe it.’

Animism is also part of this ‘Supernatural Forces’. Humans are considered part of nature and not as superior beings. A close link between the animal and human world was described by participants. Animals are often seen as the cause of illness or eating certain animal meat is viewed as being harmful during pregnancy. For example, women are told not to eat pineapple during pregnancy as it will cause their baby to have thrush, not to eat a chicken’s egg or your unborn baby will die, and not to eat sheep meat during pregnancy or your baby will be born breech. One traditional midwife told me, “Yeah, and we got some animals, porcupine, they say pregnant woman should not eat porcupine because the porcupine got plenty mouth. So when the woman eats porcupine the baby will have cleft palate.”

Several participants in this study talked about the ability of humans to take on animal form. “In our tradition when you convulse [in labor] they say it is because you become an animal.” Another participant encountered deer in the forest that she thought were humans turned into animals. She related the following:

‘Between Zekepa and Zorzor I saw eight red deer. They were dancing in front of me, so my hair started to rise. I was afraid. A hunter was coming. I was frightened. I said [to the hunter], I saw eight red deer--they came and they were dancing. He said, “These are human beings. They are dancing and they wanted to see if you are a part of them.” I was too afraid to go on, so I went back.’

In addition to belief in supernatural powers and animism, there was a mixture of traditional religious culture and modern day Christian beliefs for the participants in this study. There was a strong belief among participants that individuals/families and communities have no control over the course of events. Once God makes a decision about something, it will happen. There is a pervasive belief and understanding that an individual’s destiny is controlled by a higher power. This is often referred to as God’s will. One of the participants who works as a nurse on a hospital labor and delivery unit said, “Not everybody that goes to deliver must live – people will tell you that. When it is a woman's time to die that is why she dies.”

One woman who experienced a ruptured uterus and stillbirth supported this notion, “The only thing I have is God wanted me to deliver here [at the hospital] and God would bless me. God would make way for me and bless me.” This individual believed she delivered at the hospital after suffering a ruptured uterus and stillbirth because God wanted her to live. She believed transportation was found and she was brought to the hospital because it was God’s plan for her. Similarly, a Town Chief from a small village

where a woman died following her delivery said, “You know God is in control. Perhaps the woman would have lived. But [getting her to the hospital] was delayed. We only depended on God. Only God solves the problems.”

If a person’s destiny is in the hands of God, one would believe little can be done to change the course of events. When others with supernatural powers have influence over an individual it makes sense to keep information away from those with this power. A belief in ‘Supernatural Forces’ contributes to the first major theme, *Secrecy Surrounding Pregnancy and Childbirth*. If an individual cannot determine who has this special power, then it makes sense to keep secrets from everyone.

Conceptualization of Secrecy Surrounding Pregnancy and Childbirth

Secrecy Surrounding Pregnancy and Childbirth is an abstract theme that describes how participants understand and explain the potential danger to themselves and their unborn child – the danger of sharing information about pregnancy and delivery with others. It has a strong foundation in the magico-religious beliefs of Liberian culture and is embedded in early teachings within the bush schools or secret societies. Participants in this study provided powerful examples of the fear that women have when it comes to sharing information about their pregnancy or labor.

The conceptual categories of ‘Patterns of Communication’, ‘Female Traditions’ and ‘Supernatural Forces’ contributed to the formation of the first major theme, *Secrecy Surrounding Pregnancy and Childbirth*. The use of secrecy, as described by participants in this study, was for protective purposes yet inadvertently contributed to maternal illness

and death in Liberia because it often kept women from seeking care, assistance or help from others when problems arose.

Major Theme – Power and Authority

The second major theme, *Power and Authority*, describes how the status of the women in this study impacts upon maternal illness and death. Political and economic influences also are inherent in this theme. The second major theme includes the conceptual categories of 1) ‘Decision-Making Authority’, 2) ‘External Influences’ and 3) ‘Victimization in Childbirth’. *Power and Authority* is defined by how participants illuminate the oppression of women in the activities surrounding pregnancy and childbirth. It is influenced by the vulnerability the women in this study experienced. This vulnerability occurs because of low levels of education, poverty and human rights abuses as well as gender, race and social class.

Conceptual Category: Decision-Making Authority

‘Decision-Making Authority’ is defined as the act of a person making a decision related to a pregnancy, most often the decision to seek care, who to seek care from and when and where care will be sought when a problem occurs. It is the first conceptual category contributing to the major theme of *Power and Authority*. When women in this study faced a problem during labor they often confronted long delays in obtaining the appropriate care. One participant described such a situation. She said:

‘Sometime the man is not around. Sometime the mother-in-law is not around. So this decision needs to be made and the woman cannot make the decision by herself because in our culture the man have the final decision.’

Men are granted an extraordinary amount of power related to decision-making around pregnancy and childbirth. One nurse who worked at the outpatient antenatal clinic summed it up quite well, “While the reason is that the traditional beliefs make these people not to [make a] quick decision. They don't allow the men to be involved until it is out of hand.” She was referring to women who come to the hospital with a pregnancy-related complication. Men are excluded from the actual process of childbirth due to cultural norms yet because of their status as “decision-makers” in the family they have the power to decide if a woman is brought to the hospital for care.

Prior to her due date, one young woman went to live with her aunt and uncle, as their home was located close the hospital. She had a history of a previous cesarean section. She was living with her aunt and uncle when the contractions started with her second child. Because the aunt and uncle were away at the time, she called the traditional midwife who checked her and told her she was in labor and should go to the hospital. Although she was only 10 minutes away from the hospital, she waited four hours for her uncle to return home and make the decision to go to the hospital. During the wait she suffered a ruptured uterus and her baby died. She said:

‘The only advice my aunt told me was she was going to come back the next day. But just in case I get into labor I should send for my uncle so he can decide to take me to the hospital.’

The lack of *Power and Authority* is greatest for those living on the very margins of society who lack basic education and resources. One participant, who works for Liberian Prevention of Maternal Mortality summed things up this way:

‘The first thing is when it comes to decision making, women don't make decisions. We are not empowered, especially those that are uneducated, they don't

make decisions. If a woman is pregnant and she has a problem her husband has to come and say 'Yes, you can take her to this place.' We have to wait. If he is not around it has to be his mother or his sister or somebody next in the family.... You make decisions if you are empowered, if you have the money. If I am sitting here and I say I want to go to Phebe [hospital] and I have no money there is no decision. I can't get there. As a result we leave it to the men to decide.'

A traditional midwife told of her efforts to transfer a 21 year old woman in labor who subsequently suffered a uterine rupture, developed sepsis and died at the hospital. The husband ignored repeated advice by the traditional midwives and others in the community who had encouraged the woman to deliver at the hospital because of her history. By the time the husband finally agreed to allow his wife to go to the hospital, the baby had died and his wife never regained consciousness after the surgery. This traditional midwife expressed how the gender-based power held by men related to decision-making contributed to the young woman's death. She described the situation that occurred by relating "When the pain first started and I asked him [the husband] to transfer her, he said 'The pain just started; there is no need to refer.' "

Women in this study who had suffered a severe morbidity or died during childbirth were often referred to as a "small child," signifying their standing or low status in the community. Even when a woman has three or four children of her own she continues to be referred to as small or little by those older than her thereby reinforcing her lesser position in society. The mother of one woman who developed eclampsia during her labor stated, "My daughter was [living] in her husband's village. But when she got pregnant I sent for her to come here because she is small."

Several of the men interviewed in this study reiterated the importance of men's responsibility in decision-making. One college-educated man talked about the importance of age to one's position in society. He explained:

'Due to my level of education, in most communities, even though I have this wife someone has to take this decision. Maybe it is my uncle, maybe my father. I cannot start taking decisions on my own. No the older men must make the decision. I stay in the back and do the background.'

Another man who was interviewed works as the Officer in Charge (OIC) at a remote clinic that is an 18-hour walk from the hospital. He is a physician assistant and sometimes performs deliveries at the clinic. He said, "The husband has the final decision. I did a delivery recently where the husband refused for the woman to come to the clinic, so I had to do the delivery in town."

There is pressure within communities to follow traditional norms. One woman explained, "If you [make a] decision on your own, sometimes the people will get angry with you." The reasons for deferring to men for decision-making were described by one woman who said:

'This custom, if for instance I have my husband, my husband's brother is there and something happened in the house [to a pregnant woman]. Without informing them if I take action, if I say let me take this woman to the hospital, they will say I overlooked them. I did not consider them. That is the main reason behind this. If you told them what had happened or the condition before taking the woman to the hospital, they will feel that you have given them the full respect by putting the problem before them.'

Although women described minimal *Power and Authority* in regard to 'Decision-Making Authority', they were also concerned about causing undue problems for their family, even if the consequence was death. One of the nurses explained:

‘They think they come here [the clinic] and they are wasting their time, and some of them [the women] they feel sorry for their husband. They feel if they come to the hospital it will cost their husband a lot of money. They start to cry. One woman she died right in the clinic because she didn't want to cause a problem for her husband.’

The conceptual category of ‘Decision-Making Authority’ is a reflection of the lack of human rights afforded women in this study. The need to obtain permission from a male member of the family to seek health care or assistance with a problem during pregnancy was widely evident during interviews. The lack of ‘Decision-Making Authority’ had profound implications for the health outcomes of women in this study supporting the theme of *Power and Authority*.

Conceptual Category: External Influence

The second conceptual category contributing to the major theme of *Power and Authority* is ‘External Influence’. ‘External Influence’ is defined as the power individuals or groups have over members of their community. These influences arise from community norms and the low or lack of status young women hold in society. One participant noted the lasting effect of individual actions, “Because you are in this community it's a close community not a wider area. If you do something today, that will have a mark on you forever”

Communities are made up of clans or people inter-related to one another through birth or marriage. As a reflection of the communal way of life observed during this study, less emphasis is placed on individual rights than on the rights of the community or village. As one Town Chief told me, “Our communities are very small, very small. We are all intertwined. If somebody hurts, we follow it.” He was referring to the fact that

everyone in small rural communities knows what is going on with everyone else and what happens to one individual affects the entire community. There is a basic value system about acceptable and unacceptable behavior at the community level. It is these social and cultural processes that define the community norm. For example, one nurse described one of the community norms for a laboring woman, she explained:

‘But actually the culture, our culture and beliefs, [when] the woman is pregnant she is not suppose to cry.... In fact men shouldn't even hear it. This is why for us when a woman comes to deliver they don't cry. Even with severe pains they don't cry. They go through the pain like that’

Power and Influence in the community is held tightly by the elders or zoes, both male and female. They occupy a higher status in society due to their age. One participant noted:

‘The powerful people [are] the elders. The zoes, they call them the zoes are the one(s) that are the powerful people....When the chief wants to do something he will call the older women, the zoe women and he will tell them this is what we are suppose to do. He can convince them. He just talks to them. [He] becomes friendly with them.’

Women are taught to be obedient and dutiful to their husbands. One participant said, “You be submissive, you respect the man. He is the head. What he tells you, that is what you must do.... So that is the kind of thing we learn, that the husband he has the last say.” The idea of being submissive to your husband was described by another woman this way:

‘But they [women] listen mostly to the husband than their own self. So this too can have an impact because if something wrong is going to happen the husband is not feeling the pain. He does not know what is happening. So if I have to listen to him to say yes before I make a move while I am waiting for him to say ‘yes’...it may cause my death. It is bad.’

Another participant told of the pressure felt by pregnant women to follow the norms of the community; she related:

‘You can’t just come and say I want you people to give me my way, no you can’t just do that... You will not just come off, it will sound to them like you are not cooperating, you are selfish. Many things they will say about you and that you will not want to hear, so you will do what they think you should do.’

The second conceptual category, ‘External Influence’, describes the *Power and Authority* individuals or groups have over members of their community. Participants identified elders or zoes as having the greatest influence and control. It is these individuals young women look to for advice related to pregnancy and childbirth. ‘External Influence’ affects a woman’s actions and behaviors to care for herself and her unborn child.

Conceptual Category: Victimization in Childbirth

‘Victimization in Childbirth’ is the final conceptual category contributing to the major theme of *Power and Authority*. It is defined as the ill-treatment received by pregnant and especially laboring women. This category includes rituals surrounding pregnancy and childbirth as well as harmful interventions employed by traditional midwives and family members. These interventions are not performed with any malice on the part of the traditional midwives but rather are based on the customs and practices handed down over time.

Women trust the care and advice they receive from the traditional midwives. Because midwives are “called” into their profession or “chosen” through their family heritage it brings status and certain privilege within the community. One participant expressed her confidence in the care her midwife provided. She said: “Oh, the midwife, I

mean, they have so much experience to do their job. So, she knows her job” Pregnant women and families sometimes allow interventions that can potentially cause grave harm or injury to the pregnant woman and unborn child because they believe the midwife has a special gift to heal. As explained by one nurse currently studying to become a certified midwife:

‘So the women in the [rural communities in Liberia] when they are pregnant, when they feel like the woman should deliver in 4-5 hours. They call a group of women or men [if the time goes longer]. Someone will sit on her chest and hold her arms and legs and push on her belly. Sometime the woman's uterus will rupture and she will die.’

This practice of trying to force the baby out the birth canal was reiterated by a second nurse working in a rural clinic, “Sometimes if the woman is not ready to give birth, if it is not time, they will push, push so that the person might die.”

Women are often blamed if their labor fails to progress or they experience a problem in labor. One of the participants described:

‘So if the child came breech and the child could not come out, they believe that the mother did something or she slept with another man. That is why the child is not coming to her husband. If she doesn't confess [the name of the man she slept with] and she dies, they will say it is because of what she has done.’

Confessing, as referred to in the above passage, is admitting to the women supporting you in labor that you have had an affair during your pregnancy with a man other than your husband. One participant told of her own mother being forced to “confess” during labor:

‘They tell the woman that if [during] the time she has been pregnant she ever loved (had sex with) somebody or got any other boyfriend, she must confess and that will help her to deliver. Myself, my mother told me, when she was in labor for either my brother or my sister, they made her confess and she was forced to talk it.’

Although harmful practices are sometimes being done, women continue to trust the care they receive from the traditional midwives in their communities:

‘But some of them see it as I don't know, especially where they have those traditional midwives that are not skillfully trained. They believe in them, they sit there, they allow them to do what so ever they will do to them whether harmful or not.’

One woman in a remote village shared the following passage with me during a day spent at the rural clinic,

‘Some of them [traditional midwives] are using pepper, and putting the woman over the fire.... They take the pepper and make a ball. Then they lay her down and shove about three of them pepper balls into her vagina. Then they put a kotex on her and make her to stand over the fire. They say the heat will make the baby to come quick.’

A traditional midwife in the village confirmed her use of pepper with laboring women, by saying, “We used to pepper them...yes, it is common to stimulate contractions.”

In summary, the ‘Victimization in Childbirth’ as described by women in this study influenced their understanding of maternal illness and death. It is framed within the context of tribal culture and customs and influenced by the authority granted those called into the profession of traditional midwifery. This vulnerability to ‘Victimization in Childbirth’ contributes to the major theme of *Power and Authority* by the helplessness women felt to challenge the interventions used when a problem arises during pregnancy or childbirth; even if it can cause them harm.

Conceptualization of Power and Authority

The second major theme of *Power and Authority* provides some meaning for the human rights abuses women in this study suffered in relationship to pregnancy and

childbirth. It is influenced by participants' low levels of education, poverty, gender and social class. Women in this study had very little *Power and Authority* over their reproductive health. The power was held not by the individual woman but rather by male family members, elders or by the wider community deemed to have greater knowledge and understanding of childbearing. *Power and Authority* had immeasurable implications for the reproductive health of women in this study. The *Power and Authority* held by men, zoes, and traditional midwives had the potential to break up marriages, cause great bodily harm and even death for a pregnant woman and/or her child.

Major Theme – Distrust of the Health Care System

The third and final major theme derived from the data is *Distrust of the Health Care System*. *Distrust of the Health Care System* is defined as doubt or disbelief in the benefits of the care received within the formalized medical and nursing systems. It manifests by being fearful or uneasy with providers and what is happening around you while receiving care. It is also supported, in contrast, by the comfort and acceptance of care provided by traditional midwives. *Distrust of the Health Care System* is comprised of the following three conceptual categories: 1) 'Acceptance of Traditional Healers/Medicine'; 2) 'Barriers to Accessing Biomedical Care' and 3) 'Trust in the Community.'

Conceptual Category: Acceptance of Traditional Healers/Medicine

'Acceptance of Traditional Healers/Medicine' is the first conceptual category contributing to the major theme of *Distrust of the Health Care System*. It describes the comfort women and their families expressed in accessing care for pregnancy and

childbirth through traditional means. This included care provided by zoes, black baggers (men and women who pose as health care professionals treating pregnant women as well as family and community members at the village level), traditional healers and traditional midwives. It also refers to the use of ‘country medicine’ or various herbs and practices for health problems during pregnancy. Participants talked about special food and herbs they consume during pregnancy as well as food taboos (foods to avoid during pregnancy) which they believe will cause harm.

‘Some people say you [pregnant women] can't eat a snail. If you eat a snail the pace for you is too slow to deliver...eating snails they can cause a slow labor. The other thing [not to eat during pregnancy] is the tricky deer. Sometime traditionally our people say they [the baby] can continue to jab the midwife, jab the birth giver, jab them all. So tricky. You see. If she eats the deer the baby comes in and goes out.’

The jabbing described by this participant is what is often seen during the final stage of labor when the baby’s head rocks under the pubic bone as it makes the final maneuvers through the birth canal. Although this is a normal process, the participants viewed it as being problematic and something of concern.

A nurse who works as a supervisor in the outpatient antenatal clinic adjacent to the referral hospital shared her concern with one of the traditional food taboos she has observed, “And sometime when they start bleeding heavily after delivery their belief is some kind of animal in the bush [if] the person ate that particular animal or meat, that is why they continue [bleeding] like that.”

Another participant showed his concern about the need to avoid certain meats during pregnancy. He said:

‘If I had a pregnant woman living with me in the house I would advise them not to eat certain animals like monkey. Monkey can make yelling [cause the infant to yell] and certain animals, if you eat tricky deer, the baby will be jerking [convulsing].’

As described by participants, women and their family members often seek out care and help from traditional healers when they develop a problem during pregnancy.

One woman provided the following description of a black bagger. She said:

‘The black bag men are people who have not had formal training, some of them are nursing school dropouts, some of them are people who have worked in the hospital for long and they have observed the nurses and the doctors and some of them have worked as nurse’s aides.... They are everywhere. They used to work in the hospital as a cleaner or a nurse aide and they feel the salary is small so they go out. They know about aspirin, they act like a big doctor. They cure one or two people and the whole village trusts them.’

Black baggers were viewed as especially harmful by professional health care providers. One nurse shared her views about the black baggers. She said:

‘There are a lot of black baggers, more and more. And because of that some of the women don't come to antenatal care, they go to black baggers. They [black baggers] don't check the baby or the women's own health. The black bagger is just there to get his money. There are more now than before [the war].’

Another nurse explained why the community puts their trust into the care they receive from the black baggers,

‘The black bagger, he doesn't know the effect of whatever he is doing. All he is thinking is he is happy. And for the community people they feel this man is with us. He cares more about us [than the formalized health care system] because any problem we carry to him he will not refer us. He will always solve it for us.’

Women and family members described their use of black baggers for care during pregnancy and childbirth. One woman, who died en route to the hospital, was being cared for by a black bagger when a male family member was called to find transportation. “He [the black bagger] was over her when I got there. I saw an IV hanging up over her.” The

widowed husband, who was holding his two year old daughter when he talked with me said this about his deceased wife. “She never attended prenatal clinic. She started taking treatment from the black bagger. The man who goes around selling drugs.”

Another woman, pregnant with her tenth child, was brought to the hospital with a ruptured uterus and stillbirth. She said the following about her experience with a black bagger, “He advised me that my baby was lying down good, that I should eat different kinds of food. He gave me treatment, an injection and some pills. He told me I should not go under the sun too long.” Her 19 year old daughter who accompanied her to the hospital reinforced her mother’s story by saying “No. My mother never visited an antenatal clinic, the man [the black bagger] used to visit our town.”

A 26 year old woman, pregnant for the fifth time said of her prenatal care, “With this pregnancy I was not checked by the nurse or the midwife, only a black bagger because I was in Lofa (County) across the river.”

Anyone is able to buy medication in pharmacies throughout Liberia. It is here black baggers get their supplies before heading out into rural villages. Another participant elaborated:

‘They pass around with a few tablets in a bag and needles and syringes and unfortunately anybody can walk into a drug store and buy anything, any medication, anything they want, no questions. They can buy any quantity, stock up your bag.’

The lack of regulation of pharmacies was reiterated again and again by the health professionals who were interviewed. One nurse said:

‘We have so many pharmacies, drug stores, there's no control. There's no control. So right now if you go in town to Aber's pharmacy, right on Carey Street, you get there you will see a long queue. People just go there and buy drugs. Those black

baggers they just go there and buy their drugs from the drugstore, from the pharmacy and then they go out and they sell them.’

Pharmacies offer treatment to patients as well, as described by the mother of a young woman who died during her second pregnancy from sepsis, “Yes. They used to carry her there [to the pharmacy] for treatment. The whole family goes there for treatment”. The mother-in-law of the same young woman said, “Later on [in the pregnancy] she complained that her heart was hurting, so we took her to the drugstore and they treated her there with tablets and IV fluid.”

Another type of traditional healer often sought for care during pregnancy is a zoe or elder in a community. One nurse described the reason women often seek out care in the community rather than seeking care at a health facility:

‘Patients that come here [the hospital] they feel that the nurses will not hold them. They will not talk to them. And so they prefer to go out there and out there in the community they, the zoes or the black baggers, have little knowledge about maternal care or about the woman.’

Traditional midwives and others often offer women ‘country medicine’ to help them along during the pregnancy or for any problem that might develop in pregnancy or childbirth. One young woman described her use of country medicine after giving birth to a stillborn baby:

‘You know in the bush we don’t got no medicine, we only got some country medicine to drink. Sometime I would visit the clinic and they would give me a tablet for something and check the baby position. But for this one [pregnancy] I never really went for antenatal care.’

The conceptual category of ‘Acceptance of Traditional Healers/Medicine’ reflects the confidence pregnant women and families place in indigenous practitioners.

Traditional healers were used by the majority of women interviewed in this study and

accepted or promoted by their family members. Because of a long standing belief in traditional medicine, these practitioners have legitimacy within communities. Women and family members have less understanding of Western medicine practiced at clinics and hospitals. Because of this acceptance and comfort with the care provided by traditional healers, women have more *Distrust of the Health Care System* due to their lack of understanding and familiarity with it.

Conceptual Category: Barriers to Accessing Biomedical Care

The second conceptual category contributing to the major theme of *Distrust of the Health Care System* is 'Barriers to Accessing Biomedical Care.' Numerous 'Barriers to Accessing Biomedical Care' were identified by participants in this study ranging from lack of transportation to an understanding of the care they will receive at the clinic or hospital. Many women expressed a fear of the hospital environment or a misunderstanding of the care they would receive there. Money was also cited as the reason care could not be sought outside the community although nurses and physicians assured me no one was ever turned away from a clinic or hospital for lack of funds. One young man whose wife died during childbirth at the hospital stated, "I was not at the hospital when she died. I came [home] to look for money."

Lack of money was often cited as a reason why women did not access biomedical care. One husband shared the young couple's inability to make plans for her delivery due to lack of funds, "We didn't decide where she would deliver [during the pregnancy]. But because we were looking for money [when she developed a complication during labor] that was the problem. Before you go to Phebe [hospital] you should have funds." Looking

for money to go to the hospital delayed this family from seeking care in a timely manner. His 21 year old wife died after reaching the hospital too late.

One young woman developed seizures during labor. Her husband and father stayed behind looking for money to pay the hospital bill while others took her to the hospital. The father stated he did not go along to the hospital, “No, just her mother and the uncle [went to the hospital]. I did not go. I was behind looking for money.” Families often borrow money or do extra work to obtain money for care. Her husband stayed behind as well, “My wife was discharged and came back. I never visited the hospital. I stayed behind to get money for the hospital bill so I was not able to go.”

Another young woman wanted to give birth at the clinic but shared the reality of her situation when the time came to deliver, “I decided to deliver in Gbonota clinic or Phebe [hospital] but when I went into labor there was no car [available to take me to the hospital] or money.” A nurse, referring to road conditions explained, “Sometime the person will want to come, [to a clinic or hospital] but how will they come? There is no access to the villages.”

Women were also unfamiliar with the hospital environment and the routines or procedures of the hospital or clinic which made them afraid to access care. One traditional midwife noted, “Even some of the women themselves when you find a complication and say you have to go to the hospital, they will beg and say ‘I beg you please deliver me. I don't want to go to the hospital’”. A lack of understanding or experience with western medicine contributes to this *Distrust of the Health Care System*.

One town chief told of accompanying the traditional midwife to a woman's home to encourage her to seek care at the hospital. He said:

'I went with the midwife and advised her to go to Samay clinic. I said I think the same thing that came on your cousin is coming on you but she refused. She did not go to the clinic until she started jerking. If she would have gone to the clinic [earlier] maybe she would have her baby.'

Fear of seeking care at the hospital was expressed by several participants in this study. One community member who was close to a woman who had refused to go to the hospital noted that "Some of the people are really afraid of the hospital. In her case now she really did not want to go under the knife for the second time. That is what she was thinking." The woman had been encouraged by her midwife and others in the village to deliver at the hospital because of a previous cesarean section.

This fear of "knives" or incisions made during surgery was also described by one of the nurses who worked for 35 years on the labor and delivery ward. She said "Most of the labor patients are afraid of c-section. They believe when you come, the first thing we do here is cut."

Finally, the husband of a woman who died at home following delivery of twins described why he thought his wife and other women did not access care at the hospital or clinic:

'I can't really tell, but some of the people when they go to the hospital they are afraid that they don't know anybody there. Number two, when you go to the hospital they give you an operation, and because you don't speak English you have a fear. Maybe because she had all the children here [at home] and she had no complications, maybe she wanted to have the babies here.'

Both structural barriers, such as remoteness of a village and cognitive barriers such as fear or misunderstanding of the hospital contribute to the conceptual category of

‘Barriers to Accessing Biomedical Care’. A lack of understanding of the type of care provided at a clinic or hospital was expressed by participants in this study. These barriers add to *Distrust of the Health Care System* as experienced by many of the women, families and community members in this study.

Conceptual Category: Trust in Community

The third and final conceptual category of the theme, *Distrust of the Health Care System*, is ‘Trust in Community’. ‘Trust in Community’ is best defined as a feeling of comfort or belief in your provider or your treatment as described by participants in this study. It includes not being afraid or fearful in your surroundings and establishing a trusting relationship with a provider in the community. It is supported by interviews with women and family members as well as by participant observation at the community level. During participant observation experiences, I observed that most women did not want to leave their home or community for maternity care. Participants expressed their desire to birth in an environment which was known and comfortable to them. For instance, one participant noted that in her town, “The people that live here, they [are trusted] more than the [clinic] nurses.... Mainly they trust the people they live with.”

One traditional midwife providing care for a woman who she felt needed to be transferred to the hospital had to threaten the girl’s parents in order for them to take her to the hospital:

‘Some people they were trying to convince me to let her stay [in the village]. [They said], ‘Oh maybe she will deliver on her own’. I said no, we cannot let her stay. Carry her. I do not want to do the delivery. I even threatened them, the parents. I said You stay with the girl and go right away, when she die I will report you to the authorities”.

In response to a maternal death in one rural community, the clinic nurse observed the following, “Trust. The people in Beletanda never trusted the advice of the [clinic] midwife or the nurse. They trusted the black bagger more.”

In discussing the confidence women place in local traditional practitioners over medical personnel in the hospital or clinic one nurse said:

‘They trust these people because they come to them. They feel like those people listen to them and they solve their problem unlike the health worker who will not do that.... For us we don’t listen but the sad thing is we don’t follow what they say and we don’t explain to them what is right for them to understand.’

One nurse, whose community catchment area had four maternal deaths in the year prior to this study, said this:

‘The people really believe in the black baggers. In this country there are many villages that are not accessed due to the road conditions. So you find [black baggers] to take it upon themselves to go to [community members]. [Black baggers] build a trust in them. This is what happens. So just after building that trust to take that trust away is not easy for [people]. They, most of the time, believe in what so ever [the black baggers] tell them to do. More than we that went and learned, more than us.... They believe in them. They sit there and allow them [black baggers] to do what so ever they will do to them, whether harmful or good.’

Another young woman who was brought to the hospital with heavy bleeding during her pregnancy talked about the care she received in her community from the traditional midwife,

‘She [the traditional midwife] can help my people. I pay her \$350 LD for delivery. I went to the woman because she does not bother you. She does not check you frequently, and when you are fully [dilated] she tells you to push. Yeah, I delivered all my 4 children at home with the traditional midwife in my community.’

People are also very comfortable with receiving care at the local pharmacies as evidenced by this comment from the mother of a young woman who died in labor, “Yes. All my children have been treated at the drug store.”

‘Trust in Community’ contributes to the major theme of *Distrust of the Health Care System*. ‘Trust in Community’ was evidenced by the desire of many women and family members in this study to remain in their villages for care during pregnancy and delivery. Women preferred traditional care over biomedical care in most instances and trusted traditional providers and practices. They expressed confidence in their ability to birth at home without the assistance of the biomedical community.

Conceptualization of Distrust of the Health Care System

Distrust of the Health Care System is an abstract theme that illustrates how participants in this study understand and mistrust the formalized healthcare system and their strong beliefs that giving birth at home is better than in the hospital. It is supported by participant’s ‘Acceptance of Traditional Healers/Medicine’, their ‘Trust in Community’ and reinforced by real and perceived ‘Barriers to Accessing Biomedical Care.’

The women in this study who developed a severe complication during pregnancy as well as the family members who had a loved one die, never assigned blame or criticized the care they received at home from traditional healers or community members. In contrast there was expressed fear by participants of what could happen if they chose to go to the hospital for care during labor and birth.

Behind the House

Participants in this study used the metaphor, *Behind the House* to describe childbirth in Liberia. Through their understanding they described the Secrecy Surrounding Pregnancy and Childbirth, the Power and Authority and Distrust of the Health Care System that drives women *Behind the House* to give birth. “When a woman is in labor you take her behind the house.” Literally participants spoke of taking a woman from the house to a different place away from the men and family members to give birth; a place that would give her privacy to birth. *Behind the House* expresses the complexity of maternal illness and death in Liberia for participants in this study.

According to Spradley (1979) “cultural themes sometimes appear as folk sayings, mottos, proverbs, or recurrent expressions” (Spradley, 1979, p. 187). The overarching cultural theme, *Behind the House*, connects the underlying relationships of the three conceptual categories; *Secrecy Surrounding Pregnancy and Childbirth*, *Power and Authority*, and *Distrust of the Health Care System*. It serves to illuminate “that area of knowledge where people are not quite aware or seldom find the need to express what they know” (Spradley, 1979, p. 188). Participants in this study shared implicit knowledge through their experiences with maternal illness and death. Through these shared experiences, we can begin to understand the socio-political and cultural context of childbirth in Liberia, including practices, beliefs and traditions that influence maternal health, illness and death.

Summary

This chapter presented analysis of data from demographic questionnaires, participant observation, field notes, and individual interviews with participants. It provided a comprehensive description of the conceptual categories and major themes derived from the data. These themes were then abstracted through further analysis to develop an overarching cultural theme, *Behind the House*, to express how participants understand and describe maternal illness and death. *Behind the House* depicts an understanding of the socio-political and cultural context of childbirth in Liberia. *Behind the House* is a graphic assertion that describes the universal experience among childbearing women in Liberia; an assertion that occurs within the context of secrecy, the lack of power and authority on the part of women and the generalized mistrust of the health care system.

CHAPTER VI: DISCUSSION AND CONCLUSION

Chapter VI presents a discussion of the interpretive ethnographic theory generated from this study with findings related to the research questions and implications for nursing knowledge. This will be followed by a discussion of the limitations of the study and suggestions for future research.

This study focused on providing an understanding of childbirth and maternal illness and death through the lens of women, families and communities in order to generate an interpretive theory of maternal mortality and morbidity in Liberia, West Africa. It described aspects of the broader socio-political and cultural context of childbirth in Liberia including practices, beliefs and traditions that influence maternal health, illness and death. This study addressed the following two research questions:

1. How do Liberian women, family members and community members understand and describe maternal illness and death?
2. What are the political, social and cultural factors that influence the ways women seek care during pregnancy and childbirth?

Global feminist theory, which values women and women's experiences, served as the theoretical perspective to guide this study. The concepts of vulnerability, human rights, gender-based violence and war trauma - all interrelated and interdependent to childbirth in the post conflict country of Liberia were linked under the theoretical perspective to provide the organizing framework. Analysis of how these concepts influenced participants during pregnancy and childbirth was accomplished through a dialectical and interactive interpretation of the data (Hammersley & Atkinson, 2007). Allowing

participant voices to emerge and be reflected in the data analysis was central to this research.

The Interpretive Theory – Behind the House

The interpretive theory generated from this research explains the experience and meaning of maternal illness and death in Liberia for women, their family members and communities. The road to death or severe morbidity related to childbirth complications starts very early in the lives of women in this study. Secrecy learned at a young age in the bush schools compounded by the traditionally low status of women in Liberian society leaves women with little authority or autonomy to advocate for themselves. For participants in this study *Behind the House* became part of the everyday vernacular used when discussing childbirth. It represents the fate of a woman when she enters into labor “They go behind that house and face the pain.”

Care during pregnancy and childbirth by traditional midwives in Liberia is well documented (USAID, 2002). Sixty-one percent of births in Liberia occur in the home with the remainder delivered in health facilities with a skilled attendant. In rural areas the number of hospital deliveries decreases to 26% (LIGLIS, 2008). This has not changed substantially in the past fifteen years even with the mandate by the WHO for all women to deliver with a skilled attendant.

In 2007, a Demographic and Health Survey (DHS) of Liberia was released by the Liberia Institute of Statistics and Geo-Information Services providing population based statistics. In the time since the previous DHS in 1986, a 14 year civil war ravaged Liberia affecting women in unequal numbers. The maternal mortality rate rose from a reported

760 maternal deaths per 100,000 in 1986 to 994 maternal deaths per 100,000 in the current report. An exodus of trained health workers as well as a breakdown of infrastructure has disproportionately affected childbearing women in Liberia. Rural women in this study were often cared for by unskilled 'black baggers' who have proliferated since the end of the war, traveling from village to village under the guise of a skilled health worker.

Postpartum women in this study reflect the inequity in the educational system and the worsening of educational attainment since the war. The average years of completed education for the ten postpartum women in this study was three ($M=3$) with a range of zero to eight years. The Liberian educational system has been unstable for over 15 years because of the civil crisis. The majority of Liberians have little education with females much less educated than males. Fifty-six percent of females and 39% of males have never attended any school. Additionally, only 5% of females and 13% of males have completed secondary or higher education (LIGLIS, 2008). This lack of formal education has widened the gap of educational attainment between males and females, contributing to women's lower social status.

The interpretive theory, *Behind the House*, provides an effective way of understanding the larger social and cultural context of childbirth and childbirth related practices, beliefs and traditions in Liberia. It defines the complexity and challenges that women face in their reproductive health such as lack of decision-making authority and the low social status of young women within communities. It describes the vulnerability

of reproduction and brings forth voices that have been silenced in the past. *Behind the House* constructs the meaning of maternal illness and death in post-conflict Liberia.

Culture has a profound influence on childbirth. Participants in this study viewed childbirth related death and illness as a normal part of life. Family and community members often did not know the underlying cause of death when a woman died or understand the reason a severe pregnancy complication developed. Maternal death and illness was viewed as “God’s will” with little that could be done to change the outcome. In the eight cases of maternal death in this study, no family or community member could name or describe the medical complication that led to the woman’s death. There was a lack of understanding of physiological processes related to childbearing. Participants in this study often attributed problems faced by pregnant women to supernatural or occult forces.

The interpretive theory corroborates the work of Chapman (2006) who examined social risk and reproductive vulnerability in central Mozambique. Her findings suggest that “women’s risk perceptions correspond to gendered, corporeal experiences of social and economic marginalization” (Chapman, 2006, p. 507). Social and cultural factors such as secrecy and hiding of information influenced the ways in which women sought care for pregnancy and childbirth in Liberia. Lessons learned in the secret societies or bush schools known as ‘Sande’ influenced communication between husbands and wives as well as between young women and elders.

Women in this study were vulnerable because of low levels of education, poverty and human rights abuses. They lacked the authority to make decisions for their own care.

Because of their gender or their age - others, such as men and elders - made decisions for them. Women in this study were obedient to their husbands and elders. They trusted that authority figures would make the right decision for them. My study findings support the observation by AbouZahr (2003) that a woman's overall status in society, including economic and social vulnerability, affects her access to and utilization of health care.

This interpretive theory moves beyond the biomedical understanding of birth by contextualizing childbirth as a social as well as a biological process. It embeds the pregnant woman within a social and cultural context of witchcraft, rituals and customs surrounding childbirth and traditional healers. Findings from this study reflect the assertion of others that women prefer to be attended in childbirth by indigenous healers who understand the community norms and customs (Adams et al., 2005; Berry, 2006; Chapman, 2006). Participants in this study expressed their desire to give birth in their home community with people they know and trust. Their preference was to seek traditional care over biomedical care for childbirth in nearly every instance.

This theory contributes to a growing body of knowledge that supports a context specific understanding of the practices, beliefs and traditions related to childbirth in communities and countries with high maternal mortality. Without this understanding there is inadequate guidance about how to proceed to reach the MDG of 75% reduction in maternal mortality by 2015 (Costello, Azad & Barnett, 2006). Designing approaches to combat the disparity of maternal mortality in developing countries requires unraveling and addressing the concerns of women through respect for their beliefs and traditions.

This interpretive theory, *Behind the House*, explains how political, social and cultural factors influence the ways women seek care during pregnancy and childbirth. It illuminates how Liberian women, family members and community members understand and describe maternal illness and death. It provides us with an understanding of the traditional structures surrounding childbirth and how problems are interpreted and understood by women, communities and family members. For participants of this study, the interpretive theory offers an explanation of their experience with maternal illness and death. It is woven into the fabric of everyday life connecting practices, beliefs, and traditions.

The first major theme, *Secrecy Surrounding Pregnancy and Childbirth*, describes the hiding of information and facts about pregnancy and childbirth from others. Study findings indicated a culture of silence related to pregnancy and childbirth. This culture of silence is used by women to protect themselves and their unborn child from harm. It is rooted in early teachings from the bush schools or Sande societies and reflects traditional religious beliefs. It is during this initiation into the traditional female role that women learn the taboos of discussing menstruation, pregnancy or childbirth. Women in this study shared a lack of awareness about normal reproductive health, how to care for themselves in pregnancy and when to seek care for a problem; often hiding the fact there was a problem. Until now, no other studies have described the impact of bush schools on women's reproductive health or childbirth outcomes.

Secrecy was normalized and reinforced in this study by elders and traditional healers in the communities. Belief in supernatural power also contributed to secrecy.

Participants were often fearful that sharing information related to their pregnancy made them vulnerable to harm from others. Vulnerability to spirits or witchcraft often precluded women from seeking care for a problem in pregnancy when needed. This need to protect oneself from supernatural forces impacts care seeking during pregnancy and childbirth. These findings support earlier research conducted in developing countries articulating the need women express to protect themselves from spirits during pregnancy and childbirth (Chapman, 2006; Jansen, 2006; Maimbolwa, Yamba, Diwan & Ransjo-Arvidson, 2003).

The second major theme, *Power and Authority*, portrays the status of women in this study and how this impacts on maternal illness and death. It explains the marginalization of women and the structures that reinforce their position in the family and community. Women and traditional midwives reported the need to obtain permission from a male member of the family to seek health care or assistance with a problem during pregnancy. Because of their status in the family and community, women needed the permission of men to seek care at a health facility if a problem arose during pregnancy or childbirth. This diminished authority is corroborated in a study by Amowitz, Reis & Iacopino (2002) that focused on maternal mortality as a proxy indicator for women's human rights. They found women needed to obtain permission from their husband or male relative to seek health care and use birth control. Women's rights to reproductive health care are frequently violated in the developing world.

Women in my study often held lower status not only to men but to older women in the community. Elders or zoes were seen as having the greatest influence in a

community. Their advice and guidance was sought for pregnancy related advice due to their standing in the community. Although older women were held in high esteem, they too needed to obtain approval from the woman's husband to seek care for her. A hierarchical community structure existed with childbearing women near the bottom because of their age and gender.

Findings from this study also exposed ill-treatment women received during labor at the hands of those with more power and authority. Participants discussed beliefs, such as blaming the pregnant woman of infidelity when a complication occurred such as obstructed labor. This "blaming-the-victim" is described by Maimbolwa et al. (2003) in a study of childbirth practices and beliefs in Zambia. Consistent with my findings, women were given traditional medicine to help the labor progress only after they confessed they had been unfaithful to their husband. Similarly, women in a study by Asowa-Omorodion (1997) in Nigeria believed pregnancy complications were the result of a woman's sins. Complications were therefore viewed and accepted as punishment for these sins.

Hall (1999) describes marginalized individuals as "vulnerable to health risks resulting from discrimination, environmental dangers, unmet subsistent needs, severe illness, trauma, and restricted access to health care" (p. 89). Access to care for women in this study was restricted by the need to obtain permission from their husband or a male family member, often delaying their ability to receive much needed care. Study participants voiced how gender inequities compromise decision-making and the ability to obtain care when needed.

The third major theme, *Distrust of the Health Care System*, illustrates the misgivings participants in this study voiced about care received from the formalized health care system. Participants in this study described a comfort with traditional practices for problems experienced in pregnancy and childbirth over care from a doctor or nurse. They were fearful of “being cut on” or “going under the knife” if they went to the hospital for childbirth. Many of the participants related stories they heard of women who went to the hospital for complications during pregnancy and subsequently underwent a cesarean section. Cesarean delivery did not fit into their paradigm of childbirth. They were suspicious of doctors cutting on women during labor with many preferring to stay in their home communities even when a problem developed. Participants expressed a strong belief that traditional healers were fully equipped to handle any complication they experienced without them having to leave the community.

Even when a decision to go to a health facility was made by participants in this study, long distances as well as lack of money and transportation complicated access. In two previous studies (Chapman, 2006; Liamputtong, Uimyam, Parisunyakul, Baosoung & Sansiriphun, 2005) plural health care systems were strategically utilized by women to maximize social and biological support. This was also true of the women in my study. Many of the women utilized multiple care providers both skilled and traditional for care.

Trust was expressed by participants as a quality they embraced with traditional healers and traditional practices. Women had confidence in the traditional midwives who believe they are called into their profession or chosen by a higher power to become a midwife. Participants prioritized social norms over biological problems. It was more

important to many women in this study to follow community norms than to seek care when a life-threatening problem developed.

The fear of hospitals expressed by participants in this study is echoed in the work done by others in developing countries (Adams, Miller, Chertow, Craig, Samen & Varner, 2005; Amooti-Kaguna & Nuwaha, 1999; Berry, 2005). Women, families and community members described the structural and cognitive barriers they must overcome in order to access biomedical care. For many, these barriers were insurmountable; for others the process was a struggle. No woman described it as easy.

In summary, when woven together, the major themes of *Secrecy Surrounding Pregnancy and Childbirth*, *Power and Authority* and *Distrust of the Health Care System* form the interpretive ethnographic theory *Behind the House* to explain the experience and meaning of maternal health, illness and death in Liberia for women, their family members and communities. According to Spears (2000), “People experience the troubles and turmoil of life in ways that cannot be captured simply by biomedical comparison to normative standards of risk”. Participants in this study did not conceptualize maternal illness and death with the same biomedical constructs used in Western medical thought. The embodied experiences of participants in this study illuminated the complex context of childbirth in Liberia. Findings from this study extend our knowledge of the influence of practices, beliefs, and traditions on maternal health.

Implications for Nursing

The knowledge generated from this research has implications for nursing research, theory, and practice.

Implications for Nursing Research

Global feminist theory provided the framework for this interpretive ethnography to explore the political, social and cultural context of childbirth in rural Liberia. This theory provides a foundation to inform future research with childbearing women in developing countries. Further research with this population will be enhanced by a reciprocal relationship between the participants and the researcher. By examining the oppression of women in the developing world researchers gain a better understanding of the contextual factors that impact on the intractable problem of maternal mortality.

This approach could help us frame new questions to examine the huge disparities in birth outcomes between the developed and developing world by directing us to consider the human rights of each individual. Women in the developing world do not have the power or the influence to set the agenda addressing maternal mortality. Additional research focused on giving voice to this segment of society is needed.

In summary, unlike most recent research on the epidemiology and biomedical risk factors contributing to maternal mortality, this study focused its efforts on understanding maternal illness and death through the lens of the women, family and community members. Nursing researchers are poised to take the lead in addressing maternal mortality and morbidity by giving voice to those most affected. From this starting point, a spectrum of reproductive health issues could be explored with women in poor, developing nations.

Implications for Nursing Theory

This study takes a critical look at how the concepts of vulnerability, human rights related to reproductive health, gender-based violence and war trauma impact on maternal illness and mortality in the post-conflict country of Liberia. It examines how the relationships between these concepts help to explain the persistent and worsening trends in maternal mortality for women in Liberia. Continued development of this interpretive nursing theory provides a new vantage point from which to view the ageless problem of maternal mortality. It provides the basis for future investigations to refine the concepts and their relationships to one another. Emergence of new theories contributes to our ever expanding development of nursing knowledge. The theory of *Behind the House* validates the importance of giving voice to women. As they become aware of sociopolitical factors that affect their lives, this voice may be used to empower women. Participants frequently play an important role in the application of findings back into their own context and the broader environment (Cook, 2005).

Implications for Nursing Practice

This study provides the beginning development of an interpretive theory of maternal illness and mortality in Liberia to help guide clinical practice. The dominant discourse from this study supports the premise that health and human rights are inseparable. Providers in the organized health care system in Liberia can incorporate findings from this study into their everyday practice. Providing accurate information to women and family members about the causes of illness and death would be a small but simple start. Grounding the experience in a simple but truthful explanation could abate

some of the beliefs that witchcraft or supernatural forces caused the woman's problems or death.

Providers need to be culturally sensitive to beliefs and traditions of rural women when designing nursing interventions. In western culture, interventions are often targeted at the individual as the predominant benefactor. Individual interventions could be potentially less effective in a culture that highly values community. Community based interventions targeting not only women of reproductive age but all community members must be considered. Maternal death impacts every member of the community. Elders and husbands specifically must be included if we hope to reduce maternal morbidity and mortality significantly.

One of the goals of critical ethnography, moving people to action, was met by this study. As a midwife and researcher, I was very pleased to be asked by a group of nurses interviewed in this study to assist them in developing a tool to collect data on maternal morbidity and mortality. As participants helped to shape the emerging analysis, they expressed a desire to have a better understanding of the circumstances surrounding a woman's death or illness related to pregnancy. As one participant shared, "We [have] become accustomed to women dying."

This study provides a better understanding of the complex factors contributing to maternal illness and death in Liberia. Development of culturally relevant interventions aimed at improving maternal health can be informed by findings from this study. Understanding poor maternal outcomes at a micro level can help inform decisions and influence health policy at the larger macro levels of institutions and government.

Limitations of the Study

The primary limitation to this study was the fact that I am white and a westerner. For some participants in this study I was the first white person they had ever seen. There was an innate power difference and social status between myself and the participants in my study. When differences such as these exist, ethical dilemmas and methodological challenges are raised (Karnieli-Miller, Strier & Pessach, 2009). I was constantly cognizant of this limitation. During recruitment, informed consent and data collection the research intent and goals were repeatedly discussed. Participants were encouraged to ask questions and voice concerns at any time. I repeatedly strived for mutual dialogue with participants through review and feedback on transcripts. This helped build rapport and mutual trust. Additionally, the nurse who acted as the translator/cultural broker was widely known and trusted throughout Bong County where the study was conducted. This helped put participants at ease and to feel comfortable in their interactions with an outsider.

Another limitation of the study was language. The inclusion criteria that participants be able to speak English or Kpelle limited the participation of all others who spoke one of the 15 different tribal languages in Liberia. It is unknown whether other Liberian tribes experience maternal illness and death in the same way as those represented in this study.

The low literacy level of many of the participants was extremely challenging when phrasing questions. Participants often expressed their answers in very short, simple terms because of their lack of opportunity for an education. The ability to describe and

elaborate on a topic was often difficult for them because of a lack and variety of language skills as well as vocabulary. In order to assure the accuracy of my findings I frequently verified the emerging insights and themes through member checking. I also presented my initial findings to hospital and clinic staff as well as the county health department in order to strengthen the trustworthiness, accuracy and validity of the findings (Karnieli-Miller, Strier & Pessach, 2009).

Future Research

Theory generating research often raises more questions than it answers (Chin & Kramer, 2004). The following discussion will provide an overview of three areas that could provide new insights and enhance nursing research in this area.

The research on maternal morbidity and mortality has only begun to highlight the significance of culture on childbirth. A deeper understanding of girls' experiences in the Sande society or bush schools would be a valuable addition to this area of research. Future research could uncover the power within this women's organization and reveal ways in which this power could be used to benefit health and reproduction for future generations. Traditional beliefs and practices can often be used in positive ways to influence health and women's rights. Cultural and scientific knowledge are often congruent (Daviss, 1997). Addressing FGM which is still practiced in the Sande societies is one example. Ten UN agencies led by the WHO launched an effort to eliminate female genital mutilation in 2008. Communities that have employed a collective decision-making process have been able to successfully abandon the practice of FGM (WHO, 2008).

The experience of giving birth in the hospital from the birthing women's point of view and their satisfaction with hospital care during labor and delivery could provide insights from women who choose to seek organized medical care for childbirth. There is much to learn from studying the context of hospital childbirth in developing countries. Currently less than 50% of women in Liberia give birth in a hospital with a skilled attendant. A better understanding of how women experience childbirth within the public hospital domain is needed if progress toward reducing maternal mortality is to be achieved. Sharing this information with other women and care providers is necessary for change.

Finally, it will be important to capture men's understanding and knowledge of pregnancy complications and causes of maternal mortality. In this study men were identified as important gatekeepers to accessing care. A future study that explores men's influence on women's reproductive health and the role they can play in reducing maternal mortality would be an important addition to the research base. Insight gained from exploration into men's understanding of maternal illness and mortality could help inform development of community based interventions.

Conclusion

In summary, there are no reported studies that have captured the essence of the structural and cognitive barriers identified here by women, family and community members in post-conflict Liberia. This study adds to the literature by providing additional understanding of the socio-political and cultural context of childbirth in Liberia. It represents the reality of women, communities and families who participated in this study.

If maternal morbidity and mortality are to be successfully addressed more voices need to be heard. Uncovering the barriers to seeking care embedded in the political, social and cultural context of Liberian life could be a beginning step to explore future research and nursing interventions to address reducing maternal morbidity and mortality in the poorest countries.

This study is a starting point for social transformation. Policy makers and providers must re-examine current approaches to improve reproductive health, addressing the contextual factors and community based issues as described by the participants. Until women are bestowed full human rights and treated with respect at all times, maternal death and disability will continue. When a human rights perspective, focusing on the interest of women is used, more relevant, sensitive and culturally congruent public health programs and policies can be developed. Until that time women in Liberia will continue to die in childbirth *Behind the House*.

APPENDIX A:
MAP OF AFRICA



Map of Africa. From “Facts About African Countries”, Northwestern University, 2007, Retrieved at <http://www.library.northwestern.edu/africana/map/>

APPENDIX B:
IRB APPROVAL



Human Subjects
Protection Program

1235 N. Mountain Ave.
P.O. Box 245137
Tucson, AZ 85724-5137
Tel: (520) 626-6721
<http://www.irb.arizona.edu>

March 11, 2008

Jody R. Lori, MS
Advisor: Joyceen S. Boyle, PhD
Nursing
P.O. Box 210230

Mailing Address: 3224 Dexter Road, Ann Arbor, MI, 48103

RE: **PROJECT NO. 08-0197-02 EXPLORING CULTURAL CHILDBIRTH PRACTICES, BELIEFS AND TRADITIONS IN LIBERIA**

Dear Jody Lori:

We received your research proposal as cited above. The procedures to be followed in this study pose no more than minimal risk to participating subjects and have been reviewed by the Institutional Review Board (IRB) through an Expedited Review procedure as cited in the regulations issued by the U.S. Department of Health and Human Services [45 CFR Part 46.110(b)(1)] based on their inclusion under *research categories 6 and 7*. As this is not a treatment intervention study, the IRB has waived the statement of Alternative Treatments in the consent form as allowed by 45 CFR 46.116(d)(2). Although full Committee review is not required, the committee will be informed of the approval of this project. This project is approved with an **expiration date of 11 March 2009**. Please make copies of the attached IRB stamped consent documents to consent your subjects.

The Institutional Review Board (IRB) of the University of Arizona has a current *Federalwide Assurance* of compliance, **FWA00004218**, which is on file with the Department of Health and Human Services and covers this activity.

Clearance from official authorities for sites where proposed research is to be conducted (Site Authorization Letters) must be obtained prior to performance of this study at those sites. Evidence of this must be submitted to the Human Subjects Protection Office.

Approval is granted with the understanding that no further changes or additions will be made to the procedures followed without the knowledge and approval of the Human Subjects Committee (IRB) and your College or Departmental Review Committee. Any research related physical or psychological harm to any subject must also be reported to each committee. Approval is also granted with the condition that all site authorization letters will be submitted to the IRB prior to data collection.

A university policy requires that all signed subject consent forms be kept in a permanent file in an area designated for that purpose by the Department Head or comparable authority. This will assure their accessibility in the event that university officials require the information and the principal investigator is unavailable for some reason.

Sincerely yours,

Elaine G. Jones, PhD, RN, FNAP
Chair, Social and Behavioral Sciences Human Subjects Committee

EGJ/rkd

Cc: Departmental/College Review Committee



APPENDIX C:
SITE AUTHORIZATION LETTER —
PHEBE HOSPITAL

PROJECT REVIEW FORM**Site Authorization Letter
Phebe Hospital**

February 12, 2008

Jody Lori MS, CNM
3224 Dexter Rd.
Ann Arbor, MI

Dear Ms. Lori:

I have reviewed your request regarding your study and am pleased to support your research project entitled "Exploring Cultural Childbirth Practices, Beliefs and Traditions in Liberia". Your request to use Phebe Hospital as a research or recruitment site is granted. The research will include interviews with patients, family members, friends, community members and health care providers including indigenous healers and traditional birth attendants who have witnessed or known a woman who died or suffered a severe complication during pregnancy or childbirth. This authorization covers the time period of April, 2008 to April 2009. We look forward to working with you.

Sincerely,



Garfe Williams, MD
Phebe Medical Director

APPENDIX D:
SITE AUTHORIZATION LETTER —
AFRICARE CLINICS

PROJECT REVIEW FORM**APPENDIX C - 2**
Site Authorization Letter
Africare Clinics

February 29, 2008

Jody Lori MS, CNM
3224 Dexter Rd.
Ann Arbor, MI

Dear Ms. Lori:

I have reviewed your request regarding your study and am pleased to support your research project entitled "Exploring Cultural Childbirth Practices, Beliefs and Traditions in Liberia". Your request to use Africare clinics as a research or recruitment site is granted. The research will include interviews with patients, family members, friends, community members and health care providers including indigenous healers and traditional birth attendants who have witnessed or known a woman who died or suffered a severe complication during pregnancy or childbirth. This authorization covers the time period of April, 2008 to April 2009. We look forward to working with you.

Sincerely,

Claudette Bailey
Chief of Party
Africare - Liberia

APPENDIX E:
MAP OF LIBERIA



Map of Liberia. From “Map No. 3775, Rev. 6, United Nations, Department of Peacekeeping Operations, Cartographic Section, 2004. Retrieved at <http://www.un.org/Depts/Cartographic/map/profile/liberia.pdf>

APPENDIX F:
INTRODUCTORY INFORMATION SCRIPT (ENGLISH)

APPENDIX G:
INTRODUCTORY INFORMATION SCRIPT (KPELLE)

Gbua-ketei**M̄eni k̄o-pilar̄-nii kili-ŋa ponoi**

Goloi n̄i p̄ȳēi a gee d̄i ñono diai die daâ fáa ma da diai da ñono gbete d̄i k̄ili n̄á a gee d̄i k̄é a zeh n̄i da maa k̄óri bela, d̄i k̄é ñoli ñono a kili ŋa p̄ono tamaa. N̄úu n̄úu k̄éte-ŋai da p̄ai k̄ēi t̄i k̄ēi a goloi n̄i goi s̄oli, maa f̄uloŋ da meni k̄p̄anaŋ lonpoi su Fiibii sale-pereí mu é péle la ñoii su sale-pere-ŋai mu nyii Afele-kie (Africare) k̄aa ñei Laib̄iaí.

Kp̄eni f̄ēi ímeni n̄ákaai su, baâ naâ meni k̄p̄anaŋ támaa k̄ólŋ é pilan̄ koo ma kpaa není nyii í golŋ è saa kpaa máŋ é m̄ole meni kp̄olu tamaa su gee k̄é kođi kpaa guláa k̄é kođi, ba p̄ori ñw̄l̄ēlii í k̄é zeh maa k̄oriei n̄i su. N̄úui zeh l̄ēi nya ba Zody Lori nyii ḡaa a b̄oi Arizona. Ñokili-ŋai siai ba é l̄ŋ l̄é-ŋa b̄álo, é ñono ñeni k̄ólŋ p̄ai a meni kp̄olu kpaa kolo-fela-ŋa da saa koo-neni-ŋa poi. Ño meni maa k̄oriei k̄aa meni-ŋai d̄ia není-ŋai da t̄ēe zu b̄é Laib̄ia da d̄i k̄áyo-ŋai é péle d̄i taa-ŋai d̄ia b̄ēi-ŋai není-ŋa da m̄ole láa támaa solo b̄ó naa da saa t̄ai da k̄é la kođi.

À k̄é ba ñw̄l̄ēlii í ñeni n̄i da maa k̄óri kpaa mare k̄ēe da k̄aa í lá é pilan̄ da maa k̄óri meni ma, ba p̄ori Zody Lori kpaa n̄úui golŋ n̄i p̄ȳēi s̄ii-woo da kp̄eni sui t̄olii nonpa-ŋai n̄i d̄ia:

N̄oii-su nonpai (231) 077738434	N̄oii-su nonpai (231) 077738434	N̄oii-su nonpai (231) 077738434
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APPENDIX H:
RECRUITMENT SCRIPT (ENGLISH)

The following is the script to be read to potential participants who are interested in participating in the study and are requesting additional information. This script will be used by the PI and cultural broker/translator.

“Because you have recently experienced a severe complication related to your pregnancy or known a woman who died or suffered a severe life threatening complication while pregnant or shortly after pregnancy, you are being recruited for this study. This study is done by Jody Lori, a doctoral student at the University of Arizona. She is interested in understanding the reasons that contribute to severe complications or death in pregnancy. The study is about the experiences of Liberian women, families, and communities where women have suffered a severe life threatening complication or death during pregnancy.”

“If you agree to participate in this study, you will be asked to have 1 or 2 interviews with Jody Lori, the student, and a Liberian nurse who is acting as a translator for her in this study. These interviews will be conducted at a time and location of your choice and will be in your choice of Kpelle or English language. The interviews will be audio-recorded (if you agree to this) and written down later. If you wish not to be audio-recorded other arrangements will be made. There may be several days or weeks between interviews. The interviews will be conducted in a private place of your choice in Kpelle or English. Jody will also be participating and observing public events in the community to learn more about Liberian culture.”

“If you agree to participate in this study, your name and identity will not be revealed or associated with anything you say or do in this study and will be closely protected. You are in no way obligated to participate in this study and you may withdraw your participation at any time. Your name will not appear on these notes. Participation in this study has no effect on the services or care you receive from the clinic or hospital.”

APPENDIX I:
RECRUITMENT SCRIPT (KPELLE)

Gbuu-ketui**Núu nina-ŋa siyēē zeh maa kóriēē su**

Goloi n̄i p̄yēēi a gee dí òno diai die f̄aa ma da diai òno gb̄ete dí k̄ili-ŋa a gee dí ké a zeh maa kóri-bela dí ké w̄eli òno a kili-ŋa p̄ono támaa. Goloi n̄i ñūai p̄ai k̄ei tí k̄ei lai dia ba PI é péle seh lé-bela, tí k̄e-bela da s̄ii-woo p̄oye-bela.

Kp̄éni f̄ei í meni n̄á k̄ái su bāa n̄aa meni kp̄an̄aŋ támaa kól̄oŋ é p̄il̄aŋ koo maa kpāa nen̄i nyii í gól̄oŋ è s̄aa kpāa m̄aŋ è m̄ole meni kp̄olu támaa su gee k̄e kōdi kpāa gul̄aa k̄e kōdi, bāa n̄aa ké a zeh maa kóri-nuui da. N̄úui zeh l̄ei, nya ba Zode Lori, nyii a ḡaa a b̄di Arizona. Ij̄okili-ŋai siai ba é l̄oŋ-lee-ŋa b̄álo, é òno m̄eni kól̄oŋ a p̄a a meni kp̄olu kpāa kolo-fela-ŋa da saa koo-neni-ŋa poi. Ij̄omeni maa kóriēēi k̄aa m̄eni-ŋai dia ñen̄i-ŋai da t̄e zu b̄é Laib̄ia da dí k̄áyo-ŋai é péle dítaa-ŋai dia b̄éi-ŋai nen̄i-ŋa da m̄ole l̄aa támaa solo b̄o naa da saa t̄ai da k̄e la kōdi.

À k̄e ba f̄aa ma a gee í m̄enii n̄i da maa kóri, da p̄ai í mare k̄ei a gee í lí Zode Lori p̄onaa a gee í mare ké a gee í mare k̄e t̄ono kpāa veere su kula ñȳēēi nyii ḡaa a b̄di gé b̄o òno a Laib̄ia sale tii k̄e-nuui dono nyii kolo p̄oyei ñoseŋ maa kóriēēi sui. Mare k̄e-ŋai n̄i da p̄ai k̄ei t̄ai ma da b̄éi ba p̄ai naa w̄elii nyan a p̄ai k̄ei ís̄ii-wooi su. Da p̄ai mare k̄e-ŋai k̄ei foo-too mei kpāa woo-soŋ k̄oli. À k̄e ba f̄aa ma, ḡe ní dí b̄oye ñaa p̄olu ma. À k̄e ífe ñw̄elii é ké foo-too mei, ḡe ní meni k̄pet̄e da kp̄éni a p̄ai k̄ei naa. F̄olo kp̄é-kp̄e da l̄okuu-ŋa da p̄ai k̄ei t̄eēi mare k̄e-ŋai n̄i k̄o loai. Mare k̄e-ŋai n̄i da p̄ai k̄ei loo-pere su b̄éi ba naa w̄elii. A p̄ai k̄ei Kpelee-woo su. Zode k̄aa p̄ai k̄ei m̄eni-ŋai da-ŋa k̄ei kwa gei, gé da-ŋa maa kp̄e nyii kwa ḡe k̄útaa-ŋai sui, gé da-ŋa maa k̄ori k̄ú ȳēēi k̄úai a Laib̄ia lonii-ŋai.

À k̄e ba f̄aa ma í m̄enii n̄i da maa kóri, í l̄aa kpāa m̄aŋ seh da k̄elee nyii da p̄ori íkol̄oŋ-nii mai, fé f̄ai l̄ei. M̄enii k̄elee ba p̄ai m̄oi kpāa í géi, a p̄ai k̄ei a loo meni. Vé ȳa a kp̄a a gee í ké zeh maa kóriēēi n̄i su, k̄ere à k̄e ba da maa kóri, ba p̄ori kulai naa a t̄ai k̄elee ba ñw̄elii. Í l̄aa fé p̄ai k̄ei goloi su. Zeh maa kóriēēi n̄i fa p̄ori zeh kper̄ai maa n̄ēēi í zolo b̄o zále-pere loŋ kpāa géte ȳēēi.

APPENDIX J:
INFORMED CONSENT (ENGLISH)

Exploring Cultural Childbirth Practices, Beliefs and Traditions in Liberia

Introduction

You are being invited to take part in a research study. The information in this form is provided to help you decide whether or not to take part. Study personnel will be available to answer your questions and provide additional information. If you decide to take part in the study, you will be asked to sign or mark this consent form. A copy of this form will be given to you.

What is the purpose of this research study?

The purpose of the study is to learn about the experiences of women, family members and communities affected by a severe complication or death related to pregnancy or childbirth. We are interested to learn about factors that influence childbirth and maternal illness and death in Liberia. Specifically, the researchers want to learn about Liberian culture and the factors that influence care choices during pregnancy.

Why are you being asked to participate?

You are being invited to participate because you have had a severe complication related to pregnancy, you know or cared for someone who suffered a severe complication or died related to pregnancy or you have experience and knowledge about the problem being studied.

How many people will be asked to participate in this study?

Approximately 28-34 persons will be asked to participate in this study.

What will happen during this study?

If you agree to participate, your participation will involve 1-2 interviews about your experience. The interviews will take place in a location convenient for you and will last approximately 60-90 minutes. You may choose not to answer some or all of the questions. You are in no way obligated to participate in this study and you may withdraw your participation at any time. During the interviews, written notes will be made in order to help the investigator review what is said. Your name will not appear on these notes. Participation in this study has no effect on the services or care you receive from the clinic or hospital.

How long will I be in this study?

You will be asked to participate in 1-2 interviews lasting approximately 60-90 minutes.

Are there any risks to me?

The things that you will be doing have minimal risk. Although we have tried to avoid risks, you may feel that some questions we ask will be stressful or upsetting. If this occurs you can stop participating immediately. We can give you information about individuals who may be able to help you to deal with the stress of talking about your experiences.

Are there any benefits to me?

There are no direct benefits to participants. However, you may benefit from discussing your experiences related to childbirth.

Will there be any costs to me?

Aside from your time, there are no costs associated with this study.

Will I be paid to participate in the study?

You will not be paid for participation in this study.

Will video or audio recordings be made of me during the study?

We will make an audio recording during the study so that we can be certain that your responses are recorded accurately only if you check the box below:

- I give my permission for audio/video recordings to be made of me during my participation in this research study.
- I do not give my permission for audio/video recordings to be made of me during my participation in this research study.

Will the information that is obtained from me be kept confidential?

The only persons who will know that you participated in this study will be the research team members: Principal investigator Jody Lori and the Interpreter Gormah Cole. Your records will be confidential. You will not be identified in any reports or publication resulting from the study. Representatives of regulatory agencies (including the University of Arizona Human Subjects Protection Program) may access your records.

May I change my mind about participating?

Your participation in this study is voluntary. You may decide to not begin or to stop the study at any time. Your refusing to participate will have no effect on the services or care

you receive from the clinic or hospital. Also any new information discovered about the research will be provided to you. This information could affect your willingness to continue your participation.

Whom can I contact for additional information?

You can obtain further information about the research or voice concerns or complaints about the research by calling the Principal Investigator Jody Lori, MS, CNM, Ph.D. Candidate at 231-077738434 or the Interpreter Gormah Cole at 231-06853779. If you have questions concerning your rights as a research participant, have general questions, concerns or complaints or would like to give input about the research and can't reach the research team, or want to talk to someone other than the research team, you may call the University of Arizona Human Subjects Protection Program office at 001-520-626-6721. Please note the time in Arizona is 7 hours earlier than in Liberia.

Your Signature

By signing or marking this form, I affirm that I have read the information contained in the form or it has been read to me by the study personnel, that the study has been explained to me, that my questions have been answered and that I agree to take part in this study. I do not give up any of my legal rights by signing this form.

Name (Printed)

Participant's Signature or Mark

Date signed

Statement by person obtaining consent

I certify that I have read the informed consent document to the participant, explained the research study to the person who has agreed to participate, and that he or she has been informed of the purpose, the procedures, the possible risks and potential benefits associated with participation in this study. Any questions raised have been answered to the participant's satisfaction.

Jody R. Lori

Name of study personnel

Study personnel Signature

Date signed

Witness Signature

Date signed

APPENDIX K:
INFORMED CONSENT (KPELLE)

Kú tũa-pere poloi Ɔomeni maa kpee p̄ere é p̄ilaj Lóŋ maa solo Ɔó-pere ma, Kúlaa-laai da Kútũa-perei ma Laib̄ia.

Menii kwa l̄noi é p̄ilaj mai:

Kú í toil a gee í ké a m̄enii ní kpete-nuu da. Gili-ŋa p̄noi golbi ní sui, dí b̄oye naa a gee í íkili-ŋa sía ma à k̄e íf̄aii kpaá ífe fáa ní a gee í ké a díi ní da mea kóri núu da. À k̄e Ɔa fáa ma a gee í ké a m̄enii ní maa kóri-nuu da, ḡe ní kwa ímar̄e k̄ei a gee í íyee p̄o k̄e goloi ní su. Kwa p̄ai golbi ní da tēi ípo.

S̄pui Ɔa l̄ m̄eni maa k̄oriei ní k̄aa meni mai?

S̄pui m̄eni maa k̄oriei ní k̄aa meni mai ñya Ɔa m̄le-laai nyii nen̄i-ŋa da z̄yee kpaá dí s̄aa t̄ai da k̄e la kōi. Kwa kú k̄ili pú meni kpeteei ma é p̄ilaj lóŋ maa solo Ɔóo maa-pere su da kolo-fela da saa nyii a k̄e Laib̄ia. Meni ɲuɲ kp̄iɲ-kp̄iɲ Ɔa meni maa kóri-Ɔelai da w̄eli dí meni da kólóŋ é p̄ilaj Laib̄ia-ŋai dí tũa-pere da menii a núu líi kula t̄ai da k̄e la kōi. Kwa ɲóno ɲweli kú gólóŋ dárei ka zolo Ɔó é p̄ilaj la ká kponoi mei k̄aa-perei ma.

L̄e meni Ɔé da ímar̄e k̄ei la a gee í m̄enii ní da maa k̄orii?

Da ímar̄e k̄ei a gee í m̄enii ní da maa kóri kp̄eni f̄ei ya m̄le laa támaa solo Ɔó a t̄ai Ɔa k̄e là kōi, í m̄le-laai kólóŋ, kpaá máŋ ya w̄lo kpaan̄ a núu da nyii m̄le a dámaa kpaá é s̄aa t̄ai è k̄e la k̄oi kpaá í meni ɲá k̄ai da ítarei é p̄ilaj meni-ŋai día nyii Ɔa maa k̄orii.

Núu yee lu Ɔé p̄ai meni ní da maa k̄orii?

T̄ai da núu 28 - 34 Ɔé p̄ai m̄enii ní da maa k̄orii.

L̄e Ɔé p̄ai k̄ei m̄eni maa k̄oriei ní sui?

À k̄e Ɔa fáa ma a gee í m̄enii da maa kóri, ḡe ní ímeni maa k̄oriei su, da p̄ai ímar̄e k̄ei a mare k̄ee ton̄o kpaá feere é p̄ilaj la í meni ɲá k̄ai ma. Mare k̄ee-ŋai ní da p̄ai k̄ei Ɔéi íkaa naai, nyan̄ a p̄ai k̄ei ȳee fólo yee-ŋa 60-90. Ɔa p̄ri gbet̄ei íkili-ŋa a gee ífe da su kula kpaá gélee. Vé ȳa a kp̄a a gee í menii ní da maa kóri kpaá Ɔa p̄ri íyee kul̄ai zu a t̄ai ya ɲoli. Mare k̄ei k̄e t̄ai, da p̄ai k̄ei íwoo p̄oyei kolo ma a gee m̄eni maa kpee-Ɔelai dí

gólọ́y ̀m̀enii í m̀oì. Ílaa fé pái k̀eì g̀oìo-̀nai ńí su. Í k̀eè ̀m̀eni maa k̀óriei ńí su fé pái í k̀peráì d̀í maa ̀ba g̀eì zále-̀perei loy k̀paa máy g̀étei mui.

Tài yeelu ̀bé na pái g̀eì ̀m̀eni maa k̀óriei ńí sui?

Da pái ímaré k̀eì a g̀eè í k̀é ̀mare k̀eè k̀é kuui dono k̀paa veere su ỳeè fólo yee-̀na 60-90.

Meni k̀p̀olu da k̀áa naa ḿí?

̀M̀enii ̀ba pái k̀eì g̀eì, meni k̀p̀olu loy nó ̀bé g̀áa zu. Berei máy kú k̀ò la a g̀eè kú meni k̀p̀olu k̀perai, ̀ba pái k̀eì g̀ái ỳeè mare k̀eè-̀nai ńí da pái k̀eì a lii-too p̀olu. À k̀é nyíjì à k̀é a yá, ̀ba p̀òri k̀peráì ̀m̀eni maa k̀óriei ma a maa félaa. Kwa p̀òri kili-̀na p̀ono teèi ípo é p̀ilay núu da ma nyii pái k̀p̀oy-maa teèi ípo a g̀eè é lóno ípo é p̀ilay ̀nii too p̀olui ma g̀áa yáì.

Na pái sey da k̀élece solo ̀b̀oì zu?

Meni da ténij too fé naa a g̀eè í zolo ̀b̀ó. ̀M̀enii nó ̀ba p̀òri zolo ̀b̀oì zui nya ̀ba ̀m̀eni-̀nai kwa lónoì é p̀ilay ma nyii-̀nai kwaà tee zu é p̀ilay loy maa solo ̀b̀ó-̀pere ma.

Na pái sey da k̀peèi zen maa k̀óriei ńí su?

É kúla ítái p̀olu, sey da k̀p̀eni k̀élece fé naa nyii ̀ba p̀òri g̀beèi ̀m̀eni maa k̀óriei ńí su.

Da pái fela-̀fèi teèi ̀m̀bo zen meni maa k̀óriei ńí meni ma?

Ífe pái fela-̀fèi solo ̀b̀oì ̀m̀eni maa k̀óriei ńí meni ma

Da pái fotòo k̀paa woo síye k̀eì meni maa k̀óriei ńí su?

Kwa pái fotòo da woo síye k̀eì meni maa k̀óriei ńí su a g̀eè kú g̀ólọ́y à k̀é ̀m̀enii í mò k̀úai kú ńá k̀aa ma a ̀nèlee a k̀é ̀ba íyee p̀òo k̀é g̀álai ńí su g̀áa mu-̀perei.

̀Ñaà fáa ma a g̀eè d́í ̀joo síye t́ai ma ̀jgaa la ̀m̀eni k̀óriei ńí sui.

Kwa pái fotòo da woo síye k̀eì meni maa k̀óriei ńí su a g̀eè kú g̀ólọ́y à k̀é ̀m̀enii í mò k̀úai kú ńá k̀aa ma a ̀nèlee a k̀é ̀ba íyee p̀òo k̀é g̀álai ńí su g̀áa mu-̀perei.

̀Ñaà ténij too fé fáa ma a g̀eè d́í ̀joo síye t́ai ma ̀jgaa la ̀m̀eni k̀óriei ńí sui.

Gili-ḡa pōnoi ka pāi zolo bōi ñyēci gāa pāi kēi a loo mēni?

Diai nó pāi gónḡ-nii a gee í kè ñeni maa kóriēi ḡí sui dia ba meni maa kpee-nuu kpulu-ḡai. Mēni lāa túe-nuui ba Zude Lori (Jody Lori) é péle dí wóo su-kula-nuui Gorma Cole ma. Ímeni-ḡai kélee da pāi kēi a loo-meni. Dífe pāi í kólḡ-nii bíai gili-ḡa pōnoi tēe kpaá dí í pú tuḡ-kolo su é kúla í seḡ koloḡoi su. Núu kpulu-ḡa da pāi pāi épéle golo-pere kétei gāa Arizona mù-belaa da-ḡa nyii-ḡai da nūa mei kái da pāi goloí ḡí solo bōi.

ḡa pōri ñii maa fáleḡ-nii ñeni ḡí maa kóri meni ma?

Í kēe meni maa kóri nuu-kpului ḡí su káa a kili kúla. Ya pōri gbetēi a gee ífe góo pilaḡ kpaá íkpera meni maa kóriēi ma a tāi ba ḡwēlii. Í kperaa zeḡ maa kóriēe ḡí ma fé pāi í kperái díi ma í kpáaḡoi la é kúla zále-pere loḡ mu kpaá gétei mu. À kè tí meni nīna kélee da gḡloḡ é pilaḡ ñeni maa kóriēi ḡí ma, da pāi deēi ípo. Gili-ḡa pōnoi ḡí a pōri gēi íseḡ maa kóriēi ḡí fa lí tue-pere.

Obēe bō ḡa pōri kili-ḡa pōno da kpéni solo bōi ñyēci?

Ba pōri kili-ḡa pōno solo bōi é pilaḡ zeḡ maa kóriēi ḡí ma é kúla ñuu-kpulu-ḡai ḡí yēci nyii-ḡai da meni maa kōri é pilaḡ núu ḡomeni kpōlu da ḡoli too pōlui mai. Dí lāa túe-nuui ba Zody Lori, gbēli-ḡai ba: MS, CNM, PhD. Núui pāi dílaai sui 231-077738434 kpaá ñuu wóo su-kula-nuui náa da Laibāa noḡpai Gorma Cole sui 231-06853779. À kè mare kēe káa í lá é pilaḡ ítyāi ma bíai a meni maa kóri nuui, kpaá máḡ mare kēe da kpéni-ḡa, zeḡ maa kóriēi ḡí maa mare kee-ḡa, kpaá máḡ í meni da bō é pilaḡ zeḡ maa kóriēi ḡí ma, kpaá a kè ba wēlii í meni da bō núu da kpéni mà, ba pōri ñūai ḡí tōlii golo-pere kétei ḡí lá, Arizona nuu-kpului mei káa nuu-kpulu-ḡai 001-520-626-6721. À kè ba ḡwēlii í ñuu-kpune mei káa nuu-kpulu-ḡai toil, gili-ḡa pōnoi ḡí síye: <http://www.irb.arizona.edu/suggestions.php>.

Íyee Pōo

Ñyee pōo kēe goloí ḡí su a ñēi a gee ḡa fáa ma a gee ḡa goloí ḡí lóno, ḡa gili-ḡa pōno-ḡai kélee solo bō gāa goloí ḡí sui kpaá máḡ dí ñono mī é kúla goloí lé-nuui yēci nyii ḡāa lē

mâ, a gee ñá mare kêe-ñai kélee su a kula. Gè ní ñaâ fáa ma a gee ñá zey maa kórieei ñí da ké. Nyíñi fé ñèi a gee ñyee pòo kée goloí ñí su a pái ñá tōyâi da kélee lán-nii.

Í lása (Íyee pòo)

Ñeni maa kóri-nuui yée pòo

Vólo kúui

Ñeni ñuui è fáa ma táì è goloí solo bô lai.

Ñaâ fáa ma a gee ñá goloí ñí lono ñá ñáa lé zey maa kóri-nuui ma nyii fáa ma é ké a zey maa kóri-nuui da, kú gili-ña pòno meni ma, berei maa-nēei é sía lai, meni kpólui gáa zui da berei pori é ké la mì é sey solo bô ñomeni maa kórieei sui. Mare kêe-ñai kélee kèi, dí gélee su kùla a dí líi laa-pere.

Jody R. Lori

Golo lé-nuui lása

Golo lé-nuui yée pòo

Vólo kúui

Sère yée pòo

Vólo kúui

APPENDIX L:
DEMOGRAPHIC QUESTIONNAIRE FOR POSTPARTUM OR DECEASED WOMEN
(ENGLISH)

1. What is the name of your village?
2. What is the name of the county you reside in?
3. How far is it to the nearest health clinic from your home?
4. How far is it to the nearest hospital from your home?
5. How old are you?
6. How many times have you been pregnant?
How many babies have been born alive?
How many living children do you currently have?
7. What was the cause of death for the children who died?
8. What are your children's ages?
9. Did you receive antenatal care during this pregnancy?
10. Where did you receive antenatal care?
11. Who provided your antenatal care?
12. How many antenatal care visits did you have?
13. Who attended you for this birth (a family member, a friend, a traditional midwife, a nurse, a doctor, a certified midwife, no one)?
14. How many people live in your house?
Who are the people that live in your house (next of kin)?
15. What is your religion?
16. How many years of formal education have you had?
17. Are you employed?
What is your job?
18. What is your estimated income per month from your job?
Do you keep the money you earn?

APPENDIX M:
DEMOGRAPHIC QUESTIONNAIRE FOR POSTPARTUM OR DECEASED WOMEN
(KPELLE)

Núu-kpunc t̄ua-perc da dí meni ná káa é p̄lan la diai ma da lón maa solo b̄ó a ninai maa marc kee-ŋa

1. Íkpanaŋ l̄aa ba lé?
2. Ík̄aŋtei l̄aa ba lé?
3. É kúla ítaai su é lí zále-perc-loŋ la nyii ñeyēi a yái káa lón?
4. É kúla ítaai su é lí zále-perci kétei la káa lón?
5. Íkoraŋ káa yeelu? Ís̄ii ba lé?
6. Ba koo síye ḡici yeelu? N̄ia-pelee yeelu b̄é ba dí maa solo b̄ó a dí fului? N̄ia-pelee yeelu b̄é íyēci?
7. Lé b̄é ñia-peleei k̄é dí ké s̄aai?
8. Íñia-pelee-ŋai dí kóraŋ káa yeelu?
9. Dí lón mei káa-perc l̄è ȳa t̄ai í k̄è la kōoi?
10. Mí b̄é dí lón mei káa-perc l̄è naa ȳai?
11. Gb̄ee b̄é ñóŋ mei káa-perc l̄è ȳai?
12. T̄ai yeelu b̄é í lón mei káa-perc l̄ée n̄a kaa k̄è yai?
13. Gb̄ee b̄é k̄è í kole í ké f̄loŋ solo b̄oi (íkaa-yoo, íbar̄aŋ-nuu, v̄ia-lee zooi, sale tii maa kóri-nuu, d̄ata, v̄ia-lee zoo nyii kolo káa ñyēci kpa a núu da fé ké ní naa)?
14. Núu yeelu b̄é ḡaa íperci mui? Gb̄ee-ni b̄é íperci mui?
15. Íȳala-perci ba lé?
16. Kóraŋ yeelu b̄é íseŋ k̄ol̄oŋ lai?

17. Íkaa tíi kēi? Dii ɓa lé?

18. Yeele ɓé da ífela fè la yálon ma é kúla ítii kéei sui? ɓa gápai laâi kè nyii ɓa zolo
ɓôii?

APPENDIX N:
DEMOGRAPHIC QUESTIONNAIRE FOR FAMILY AND COMMUNITY
MEMBERS (ENGLISH)

1. What is the name of your village?
2. What is the name of the county you reside in?
3. How far is it to the nearest health clinic from your home?
4. How far is it to the nearest hospital from your home?
5. How old are you?
6. How many people live in your house?
Who are the people that live in your house (next of kin)?
7. What is your religion?
8. How many years of formal education have you had?
9. Are you employed?
What is your job?
10. What is your estimated income per month from your job?
Do you keep the money you earn?
11. What is your relationship to the woman who died or became sick during her pregnancy?
12. How long have you known her?

APPENDIX O:
DEMOGRAPHIC QUESTIONNAIRE FOR FAMILY AND COMMUNITY
MEMBERS (KPELLE)

Núu-kpunc tûa-perc da dímeni ná-kaai é pílaj la díkayoo-raj dia da dí taa-bclai

1. Íkpanaj láa ba lé?
2. Kāṅtei láa ba lé íkaa zui?
3. É kúla ítaai su é lí zále-perc loṅ lá nyii ñeyēi a yâi gáa léṅ?
4. É kúla ítaai su é lí zále-perc kétei la ñeyēi a yâi gáa léṅ?
5. Íkoraj káa yeelu? Íkaa a lé sii-nuu?
6. Núu yeelu bé íperci mui? Gbēe-ni bé íperci mui?
7. Íyála-perci ba lé?
8. Kóraj yeelu bé íseṅ kólṅ lai?
9. Íkaa tí kēi? Díi ba lé?
10. Yeelu bé da ífela fē la yáloṅ ma é kúla í tíi kēci sui? Ba gāpai láai kē nyii ba zolo bōi?
11. Í gbēe ba nenii sàa kpaa nyii kòle tãi è kē la koōi?
12. Í gólṅ a tãi yeelu?

APPENDIX P:
INTERVIEW GUIDE FOR POSTPARTUM WOMEN (ENGLISH)

Interview #1

The first interview begins with introductions. The informed consent will be reviewed highlighting the purpose of the study, the interview process, confidentiality, and the freedom to withdraw at any time from the study. An introduction to the process of the first interview will be given including time, purpose of tape recorder and plans for the next interview. The demographic questionnaire will be completed at the first interview. Interviews will be identified with a code rather than a name. The translator/cultural broker will ask questions in Kpelle and translate them into English for the researcher. The interview will be audio-taped if permission is given by the participant and transcribed later.

Interview Questions:

- 1.) "Tell me about your pregnancy"
- 2.) "Could you tell me some traditional things women do to stay healthy during pregnancy?"
- 3.) "Did you see anyone for care (traditional birth attendant/nurse) during your pregnancy?"
- 4.) "Tell me about how you decided where to give birth?"
- 5.) "Tell me about when you first noticed a problem during your pregnancy?"
- 6.) "Tell me what you think caused you to become ill during this pregnancy?"

Interview #2

The second interview again begins with introductions. The informed consent will be reviewed highlighting the purpose of the study, the interview process, confidentiality, and the freedom to withdraw at any time from the study. Interviews will be identified with a code rather than a name. The translator/cultural broker will ask questions in Kpelle and translate them into English for the researcher. The interview will be audio-taped if the participant agrees and transcribed later.

"Last time we met we discussed your pregnancy and the kinds of things you did to stay healthy during the pregnancy as well as when you first noticed a problem."

- 1.) "Tell me about making the decision to go to the clinic or hospital for help?"
- 2.) "Tell me about the experience of getting to the clinic/hospital."

- 3.) “Tell me about when you first arrived at the clinic/hospital”
- 4.) “Tell me about your stay in the clinic/hospital.”
- 5.) “What advice would you give other women about going to the clinic/hospital?”
- 6.) “What advice do you have for me about how we can help prevent women from becoming ill or dying during pregnancy?”

APPENDIX Q:
INTERVIEW GUIDE FOR POSTPARTUM WOMEN (KPELLE)

#1 Kili-ɲa pōno solo ɓo kolo ɛ pilaŋ la lonii ma neni-ɲai dí lón maa solo ɓó-pere ma.

Gili-ɲa pōnoi kóo a pilaŋ a meni ɲáa léɛ. Da p̄ai meni ɲáa léɛi ɲí su k̄ai menii da zɛɲ maa k̄rii meni mai, gili-ɲa pōnoi ké-pere, loo-pere su da berei ɓa k̄e w̄lii í kúla la zui ɓa p̄ri ḡei lai. Meni ɲáa léɛi ɛ pilaŋ la berei ma gili-ɲa pōnoi a p̄ai solo ɓói lai, ḡaa p̄ai l̄ei ȳa ɛ péle la t̄ai ma m̄eni da ɲoo-siyei k̄ei meni mai da m̄eni kpetɛɛi ɛ pilaŋ la gili-ɲa pōnoi gb̄lii ma. Núu-kpune t̄ua-pere da ɲomeni ɲa-kaai a p̄ai kpēi a gili-ɲa pōno solo ɓooi maa-ɲuɲ t̄ai. Gili-ɲa pōno solo ɓóooi ɲí p̄ai kolonii a a ɲei ké-maa kére núu láa f̄ei. ɲóo su-kula núui kpa a m̄aɲ zɛɲ lé-nuui a p̄ai mare k̄e k̄ei Kpeleɛ-woo su dí zu kula a Kwii-woo núui m̄i ɲw̄lii a gili-ɲa pōno-ɲai. Gili-ɲa pōno solo ɓóooi ɲí a p̄ai k̄ei núu-woo siye k̄oli su. À k̄e ɓa f̄aa ma ḡe ní dí ɓóye kolo ma.

Gili-ɲa pōno solo ɓooi maa mare-kɛɛ-ɲai

1. Íkooi maa meni ɓó má.
2. ɓa p̄ri meni da-ɲaa ɓói má ɛ pilaŋ la m̄eni-ɲai día nyii neni-ɲa da k̄aa ḡe t̄ai da k̄e la koɔi nyii díkoloi ké ɓó a bonooi?
3. Í núu da k̄aa ɛ kpɔɲ maa t̄e ɲo (k̄one maa-fulɔɲ ké nuu kpa kwí sale ké-nuu) t̄ai í k̄e la koɔi?
4. Mó má berei í gb̄ete la a ḡe í lí ɓéi ɓa ɲw̄lii í ímaa fulɔɲ naai?
5. Mó má meni-ɲai k̄e a ȳa t̄ai í k̄e la koɔi?
6. Mó má lé ɓé ḡe íke k̄ole t̄ai í k̄e la koɔi?

Kili-ɲa pōno solo ɓoo #2

Gili-ɲa pōno solo ɓóooi veerei kóo a p̄ai pilanii a meni ɲá léɛ. Da p̄ai meni ɲá léɛi ɲí su k̄ai menii da zɛɲ maa k̄rii menii mai, gili ɲa pōnoi ké-pere loo-pere su da berei ɓa k̄e ɲw̄lii í kúla la zui ɓa p̄ri ḡei lai. Gili-ɲa pōno solo ɓóooi ɲí a p̄ai kolonii a ɲei ké-maa kéle zɛɲ lé-nuui láa f̄ei. ɲóo su kula-nuui kpa zɛɲ lé-nuui a p̄ai mare k̄e k̄ei Kpeleɛ-woo su dí zu kula a Kwí-woo núui m̄i w̄lii a gili-ɲa pōno-ɲai. Gili-ɲa pōno solo ɓóooi ɲí a p̄ai k̄ei woo-siye k̄oli su a k̄e núui a f̄aa mà ḡe ní dí ɓóye kolo ma.

Tāi kú kòyay lai kú meni kpetée kè é pīlay la íkooi meni ma da berei í gè la íkoloi ké Ẹ̀ò a bonóoo íkooi sui é péle la òmeni-ḡai kè a yai.

1. Mó mâ òmenii Ẹ̀a gbetēi íkili-ḡa a gee í lí zále-pere lònḡ lá kpaa gétei lá kponḡ mâa meni mai.
2. Mó mâa meni Ẹ̀a tee zu í kée lii zále-perei lai.
3. Mó mâ tāi maa-ḡuy í li la zále-perei lai.
4. Mó mâ tāi í gè la zále-perei lai.
5. Lia-woo lé kée Ẹ̀é Ẹ̀a pòri deēi òneni kpéli-ḡai pò a gee dí lí zále-perei lai?
6. Lia-woo lé kée Ẹ̀é gáa í yēei òmenii ma nyii pái kponḡ mâa teei òneni-ḡai pò a gee dí kpéra kòleei kpaa saai tāi da kè la koḡi?

APPENDIX R:
INTERVIEW GUIDE FOR FAMILY MEMBERS (ENGLISH)

Interview #1

The first interview begins with introductions. The informed consent will be reviewed highlighting the purpose of the study, the interview process, confidentiality, and the freedom to withdraw at any time from the study. An introduction to the process of the first interview will be given including time, purpose of tape recorder and plans for the next two interviews. The demographic questionnaire (with data about the woman) will be completed at the first interview with significant others if the woman has died. Interviews will be identified with a code rather than a name. The translator/cultural broker will ask questions in Kpelle and translate them into English for the researcher. The interview will be audio-taped if permission is given by the participant and transcribed later.

Interview Questions:

- 1.) "How long have you known the woman?"
- 2.) "What is your relationship to her?"
- 3.) "Did anything about this pregnancy seem different to you from her other pregnancies?" (if multiple pregnancies)
- 4.) "Could you tell me some traditional things women do to stay health during pregnancy?"
- 5.) "Tell me about how women or families decide where to give birth?"
- 6.) "Who makes the final decision about where a woman will give birth?"
- 7.) "Tell me when you first thought there might be a problem."
- 8.) "Tell me what you think caused her to become ill during this pregnancy?"

Interview #2

The second interview again begins with introductions. The informed consent will be reviewed highlighting the purpose of the study, the interview process, confidentiality, and the freedom to withdraw at any time from the study. Interviews will be identified with a code number rather than a name. The translator/cultural broker will ask questions in Kpelle and translate them into English for the researcher. The interview will be audio-taped if the participant agrees and transcribed later.

"Last time we talked about your relationship to the woman and about things women do to stay health during pregnancy as well as when you first noticed a problem."

- 1.) "Tell me about when you first arrived at the clinic/hospital"
- 2.) "Tell me about her stay in the clinic/hospital."
- 3.) "What advice would you give other women about going to the clinic/hospital?"
- 4.) "What advice do you have for me about how we can help prevent women from becoming ill or dying during pregnancy?"
- 5.) "Tell me about making the decision to go to the clinic or hospital for help?"
- 6.) "Tell me about the experience of getting to the clinic/hospital."

APPENDIX S:
INTERVIEW GUIDE FOR FAMILY MEMBERS (KPELLE)

Kili-ɲa pɔno solo bɔ-kolo ɛ pilan ikaayɔ-ɲai dia

Íkaayɔ-ɲai da íweli ke-maa neni-ɲai nyii dí meni-ɲa kâa kpaa dí kpáan a nenii tɛe meni sɔli támaa su kpaa saa tãì è kè la koði kpaa máy núu-kpune solo bɔ-pere sui. Pɔri a pãì kèi naa a gee í lóno òeyãai dí káayɔ-ɲai pɔ dia-ɲai da tee kolo-fela-ɲa su da berei díkaayɔ-ɲai da dímaa meni su-sãai.

Kili-ɲa pɔno solo bɔɔ #1

Gili-ɲa pɔnoi kɔɔ a pilan a meni ɲáa léé. Da pai òmeni ɲáa lééi ɲí su kãai òmenii da zɛɲ maa kɔri òmeni mai, gili-ɲa pɔnoi ké-pere loo-pere su da berei ba kè òwéli í kúla la zui ba pɔri gèi lai. Meni ɲáa léé ɛ pilan la berei ma gili-ɲa pɔnoi a pãì solo bɔi lai gáa pãì lèi yá ɛ péle la tãì mã, òmenii da ɲoo síyɛi kèi meni mai da meni kpetɛɛi ɛ pilan la gili-ɲa pɔnoi veerei ma. Núu-kpune tũa-pere da ɲomeni ɲá kãai ɛ pilan není ma a pãì kpeɛi a gili-ɲa pɔno solo bɔɔɔi maa ɲuɲ tãì à kè ònenii è sãa. Gili-ɲa pɔno solo bɔɔɔi ɲí a pãì kólɔnii a ɲɛi ké-maa kéle núu láa fèi. ɲóo su kula-nuui kpaa zɛɲ lé-nuui a pãì mare kèe kèi Kpelee-soo su dí zu kula a Kwíi-woo ònuui mì wélii a gili-ɲa pɔno-ɲai. Gili-ɲa pɔno solo bɔɔɔi ɲí a pãì kèi wóo siyɛ kɔli su a kè ba fãa ma gè ní dí bɔye kolo ma.

Kili-ɲa pɔno solo bɔɔɔ maa mare-keɛ-ɲa

1. Ònenii ɲí kólɔɲoo yèe a ké a tãì yeelu?
2. Í gbèe ba ònenii ɲí?
3. Meni da kãa gooi ɲí ma gáa a da kpéni íɲɛi ɛ kúla gbéli-ɲai pɔlu? (a kè dãmaai)
4. Ba pɔri meni da-ɲa bɔi mã ɛ pilan la òmeni-ɲai dia nyii není-ɲa da kãa gè tãì da kè la koði nyii dí koloí ké bɔ a bonóɔɔi?
5. Mó mã berei není-ɲa dí káayɔ-ɲai da gbète dí kili-ɲa bɛi da pãì dílon maa solo bɔi naai?
6. Gbèe ba fãa ma bɛi není ɛ ɲólɔɲ maa solo-bɔ naai?
7. Mó mã tãì ba gòlon la a gee meni da a pãì kèi.
8. Mó mã òmenii gè ònení ké kòle tãì è kè la koði.

Kili-ɲa pɔno solo bɔɔɔ #2

Gili-ŋa pōno solo bōoɔi veerei kóo è ŋóno pìlanj a meni ŋáa léé. Da p̄ai òmeni ŋáa lééi ŋí su k̄ai òmenii da zej maa k̄ri òmeni mai. Gili-ŋa pōno solo bōoɔi ŋí a p̄ai k̄lonii a ŋei-ke maa kéle núu láa f̄ei. Ŋóo su kula-nuui kpa a zej lé-nuui a p̄ai mare k̄e k̄ei Kpelee-woo su dí zu kula a Kwíi-woo ònuui m̄i w̄elii a gili-ŋa pōno-ŋai. Gili-ŋa pōno solo bōoɔi ŋí a p̄ai k̄ei woo-siye koli su a k̄e ònuui a f̄aa ma ḡe ní dí b̄oye kolo má.

T̄ai tonɔ da kú meni da b̄o é p̄ilanj núu liée sale-pere lá maa kp̄ee meni ma. Kú ŋóno lòno é p̄ilanj ka n̄eni ká lao-laai ma da òmeni-ŋai n̄eni-ŋai da ḡe a gee díkolɔi é léé a bonoóo t̄ai da k̄e la koói é péle t̄ai ma da ḡòlɔj la a gee meni da a kei.

1. Mó má t̄ai maa-ŋuj í ò la zále-perei lai.
2. Mó má t̄ai í k̄e la zále-perei lai.
3. Lia-woo lé k̄e b̄e ba p̄ri deēi òn̄i kp̄eli-ŋai p̄o a gee dí lí zále-perei lai?
4. Lia-woo lé k̄e b̄e ḡaa íȳei òmenii ma nyii p̄ai kponj máa teēi òn̄i-ŋai p̄o a gee dí kp̄era k̄lei kpa a saai t̄ai da k̄e la koói?
5. Mó má berei ba ímeni kpet̄ei k̄e la a gee í lí s̄ale-pere lá kponj-maa meni mai?
6. Mó má dárei ba zolo b̄o a gee í k̄e lí zále-perei lai.

APPENDIX T:
INTERVIEW GUIDE FOR COMMUNITY MEMBERS (ENGLISH)

It is anticipated 1-2 interviews will be held with this group of participants. The interview begins with introductions. The informed consent will be reviewed highlighting the purpose of the study, the interview process, confidentiality, and the freedom to withdraw at any time from the study. An introduction to the process of the first interview will be given including time, purpose of tape recorder and plans for the next interview. Interviews will be identified with a code rather than a name. The researcher will ask questions in English. The interview will be audio-taped if the participant agrees and transcribed later.

Interview Questions:

- 1.) “Have you ever known or cared for a woman who died or suffered a severe complication related to pregnancy and childbirth?”
- 2.) “Could you tell me some traditional things you know that women do to stay health during pregnancy?”
- 3.) “Tell me about any cultural practices women participate in that may affect their health during pregnancy?”
- 4.) “Tell me about what you know about how women or families decide where to give birth?”
- 5.) “Who usually makes the final decision about where a woman will give birth?”
- 6.) “What advice would you give women about going to the clinic/hospital?”
- 7.) “What advice do you have for me about how we can help prevent women from becoming ill or dying during pregnancy?”

APPENDIX U:
INTERVIEW GUIDE FOR COMMUNITY MEMBERS (KPELLE)

Kili-ɲa pōno solo-ɓo kolo é pɪlan ɪtaai su-ɓelai dia

ɪtaai su-ɓelai da zále tii-ke-ɓelai da kili-ɲa pōno tɛɛ é péle kú núu-polo-ɲai dí núu ɓálo-pere da dítu-a-pere polo-ɲai lónj maa solo-pere su, golo pōye-ɓelai kpaá zɛɲ lé-ɓelai zále tɛɛ-ɓelai, golo-fela mei-kaa-ɓelai, vɛɛ-lee zoo-ɲai é péle diai dia dí tareei kére nyay díyee fé ké ní ñení mei káa-perei ɲí su.

Kú láai la kili ɲá-pono solo ɓóoo 1-2 a pái kɛi ñúai ɲí sáma. Gili-ɲa pōnoi kóo è pɪlan a meni ɲáa léɛ. Da pái meni ɲá léɛi ɲí su káai ñenii da zɛɲ maa kōrii meni mai, gili-ɲa pōnoi ké-pere loo-pere su da berei ɓa kè ɲwɛlii í kúla la zui ɓa pōri gɛi lai. Meni ɲáa léɛi é pɪlan la berei ma gili-ɲa pōnoi a pōri solo ɓoi lai gáa pái lɛi yá é péle la tã ma ñenii da ɲoo siyei kɛi meni mai da ñeni kpetɛi é pɪlan la gili-ɲa pōnoi gbɛlii ma. Gili-ɲa pōno solo ɓóooi ɲí a pái kolonii a ɲei-ke-maa kéle núu lá fɛ. Zɛɲ lé-nuuu a pái mare-ɲa kɛi Kwíi-woo su. Gili-ɲa pōno solo ɓóooi ɲí a pái kɛi wóo-siye kōli su a kè ñúui a fãa ma gè ní dí ɓōye kolo ma.

Kili-ɲa pōno solo ɓóoo maa mare kɛɛ-ɲa

1. ɓa tá wólo gólɔɲ kpaá í kpáan a ñení da nyii sàa kpaá é mōle kolo-fela támaa yɛɛi tã è kè la koɔi kpaá lónj maa solo ɓó-pere sui?
2. ɓa pōri meni da-ɲa ɓoi mà nyii í gólɔɲ ñení-ɲa da gè tã da kè la koɔi a gee dí kolo é léɛ a bonoo?
3. Mó mà ñeni nyii kélee ká gè a kátu-a-pere poloi nyii ñení a kolo-fela solo ɓo zu tã a kè la koɔi.
4. Mó mà ñenii í gólɔɲ é pɪlan ñení kpaá ɲokáayoo-ɲai dia ɓéi berei da gbɛte la ɓéi dí dílonj maa solo ɓó naai.
5. Gbɛɛ ɓa fãa mà ɓéi ñení é ɲolónj maa solo ɓó naai?
6. Lia-woo lé kée ɓé ɓa pōri deɛi ñení-ɲai pó a gee dí lí zále-perei lai?
7. Lia-woo lé kée ɓé gáa íyɛɛi ñenii ma nyii pái kponj maa tɛi ñení-ɲai pó a gee dí kpéra kōlei kpaá saai tã da kè la koɔi?

APPENDIX V: CODEBOOK

Codeword	Definition
ACCESS1	Refers to the ability or attempt by a woman and/or her family to access formalized nursing or medical care as in a clinic or a hospital.
ACCESS2	Refers to the ability to attempt by a woman and/or her family to access care through a traditional healer, zoe, black bagger, pharmacy or other person outside the formal health care system.
ADVICE	Refers to information, opinions or recommendations offered to a pregnant woman to guide her action or conduct. Often given from an older person or elder in the community or family. A string of information given to guide behavior.
AMULET	Refers to any object that protects a person from trouble. Religious objects often serve as amulets.
ANIMISM	Refers to the belief systems that attribute souls or spirits to animals, plants and other entities, in addition to humans. Humans are regarded on a roughly equal footing with animals, plants, and natural forces. It is morally imperative to treat these agents with respect. In this world view, humans are considered a part of nature, rather than superior to, or separate from it.
ANNOUNCING A BIRTH	Refers to the announcement to a community that a baby has been born by singing and dancing in the street. This is not done until after delivery of the placenta.
AUTHORITY	Refers to those who have the power of decision-making or power over others usually those younger than themselves or in some cases male over female. Those who are looked up to for advice.
BEHIND THE HOUSE	Refers to the place they take a woman to deliver so no men will know about it. Sometimes it is in a bathroom or on a plantation. Men are not suppose to know what happens to a woman during labor and childbirth. Related to the secrecy surrounding childbirth in Liberia.
BELIEFS	Refers to any of the beliefs including self-care beliefs, food-related beliefs or supernatural beliefs related to or having an effect on pregnancy and childbirth.
BLACK BAGGER	Refers to the non-trained men and women who pose as health care professionals treating pregnant women as well as other family and community members in the community. Often sought out for care by pregnant women when they believe they are having a problem.
CALLING	Refers to the belief that one is called by god to be a traditional healer or midwife or that the power to heal has been passed down to you from within your family line.
CLANS	Refers to a group of people united by kinship and descent, which is defined by perceived descent from a common ancestor. Can be associated with specific tribes or sub-groups of tribes in Liberia as well as ancestors. Clans are patria-lineal in Liberia.
COMFORT	Refers to an understanding of your surroundings or familiarity with routines. Feeling at ease with the people around you providing care to you or helping you with your pregnancy in tangible ways.

COMMUNICATION	Refers to the act of (or lack of) conveying information from one person to another in the oral form. Transferring knowledge or advice on a given problem or condition specifically related to maternal morbidity and mortality.
COMMUNITY NORM	Refers to shared social and cultural processes shared by a group of individuals that make up a community or shared living space. The rules and regulations of the community in which a person lives. Basic orientation about right and wrong, acceptable and unacceptable behavior.
CONCERN	Refers to the commitment of meeting the needs of or providing the care needed to those around you either family members, friends, community members of patients. Worrying about the needs of others.
CONFESSING	Refers to the belief that when a woman has an obstructed labor she must confess she has slept with another man other than her husband. After she does this her labor will progress and she will be able to give birth.
CONFIDENCE	Refers to being certain that a chosen course of action is the best or most effective given the circumstances. In this situation it refers to a subjective, emotional state of mind in ones self or another's capability to help or assist when a problem arises.
CONFUSION	Refers to not understanding the qualifications and/or education of the person providing medical care.
COUNTRY MEDICINE	Refers to the traditional things women do to stay healthy or get healthy during pregnancy and childbirth. This includes dietary customs and use of herbal remedies that are readily available in the community or nearby surrounding area.
DECISION MAKING	Refers to the act of a person making a decision related to the pregnancy, most often the decision to seek care, who to seek care from and when and where care will be sought when a problem occurs.
DELAY	Refers to not accessing medical care in a timely manner when a problem first presents itself by not recognizing it is a problem or for some other reason identified by the person making the decision. A lapse of time that impacts or has the potential to impact a health outcome.
ELDERS	Refers to those people in the community who are in places of authority. Usually they are older men or women often referred to as zoes or traditional healers. They hold a particular position of responsibility within the community or family.
FEARS	Refers to distrust of people or particular situations. A feeling of anxiety or concern toward a person or place when something is questionable or unknown.
FEMALE CIRCUMCISION	Refers to the procedure done to young girls in Liberia at the "bush schools" that involves partial removal of the external female genitalia. It is a traditional/cultural procedure that is done with the consent of the girl's parents due to the young age of the child.
FOOD TABOOS	Refers to the foods that are forbidden to be eaten during pregnancy or believed to have an impact on the mother or the developing fetus if they are consumed.

GOD'S WILL	Refers to the belief that ones destiny is controlled by god with no personal responsibility for any outcome. Depending on god to solve your problems. Belief that all is controlled by a supernatural power and individuals/families/communities have no control over the course of events. Once god decides something will happen, it happens.
HEALTH EDUCATION	Refers to the bio-medical based health information given to women, family members, and community members by health care professionals related to antenatal care, pregnancy, delivery, and postpartum care as well as care of the newborn.
INFLUENCE	Refers to having control or power over someone; in particular the power of men over women and elders over young people.
INNOCENCE	Refers to the knowledge base of a person who does not have an accurate understanding about pregnancy and or childbirth. The state of unknowing used in this situation to describe those with little or no experience to draw from.
INTERVENTIONS	Refers to the act of intervening when a problem related to pregnancy or childbirth has been identified. An act that is done to influence events or prevent an undesirable outcome.
ISOLATION	Refers to being alone or separated from others by geographic remoteness. Being secluded or separated. In this case refers to isolation during pregnancy or especially once labor has begun.
LOVING	Refers to a person (man or woman) having an extramarital affair.
MANPOWER	Refers to the number of trained professional staff (nurses, doctors, certified-midwives) that are available to provide care for the population.
MATERNAL MORTALITY	Refers to the death of a woman while pregnant or within 42 days (or one year for late maternal death) of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.
MEN'S RESPONSIBILITY	Refers to the authority of men to direct and take action in the family and community setting. Specifically it refers to the authority surrounding issues related to pregnancy, childbirth and seeking care when a problem has been identified.
MONEY	Refers to the need for or importance associated with money when making the decision to seek care for a problem during pregnancy.
OBSTRUCTED LABOR	Refers to the obstetrical complication of an abnormally long labor due to some obstruction not allowing the woman to have a normal vaginal delivery.
PALABA	Refers to a tribal word used by the Kpelle tribe in Liberia to describe confusion or force. To have conflict or fighting among two or more people. To decide things by fighting and not by discussion.
POWER	Refers to the influence and control in a village or over a person and the actions of that person. The ability to influence someone's judgment. Often held by zoes, the elderly and men.
REASONING	Refers to critical thinking skills or logical thinking to draw conclusions or find results. How decisions are made related to pregnancy and accessing care when needed by the pregnant woman, her family, or her care givers in the community.

REFERRAL	Refers to the act or the process of transferring from one location to another; specifically transferring to a health facility such as a clinic or hospital.
REGULATION	Refers to laws, rules and policies in the form of laws and regulations that govern or spell out what happens when someone violates them. They express community norms.
RESOURCES	Refers to the ability or the capacity need to take action; someone or something that is a source of help or information when decision-making is occurs.
RESPECT	Refers to the deference or reverence for elders. The admiration, consideration, regard and esteem given to older men and women in Liberian culture.
RITUALS	Refers to the female genital cutting done in the bush schools or secret society to young girls.
SECRECY	Refers to not telling anyone when you are in labor that labor has started. Hiding your pregnancy or your labor. Hiding facts about pregnancy and childbirth or sickness related to pregnancy and childbirth from others.
SECRET SOCIETY	Refers to the secret societies that exist in Liberian culture. The women's society is call Sandi and the men's Poro. These are also referred to as the 'bush schools'. Young men and women attend these schools separately for 1 month to 1 year depending on the location. For girls it is the place they learn to cook, clean, care for their family and future husband. It is also the place where FGM takes place.
SELF-CARE	Refers to the things people do to care for themselves and to help them stay healthy during pregnancy. Special things such as not lifting heavy things, not doing hard work, and eating special foods.
SMALL CHILD	Refers to a young person. This person may have 3 or 4 children of their own but they are still referred to as small or little by those older than themselves. They also refer to themselves this way reinforcing their position in society.
SPIRITUALITY	Refers to care of the soul or spirit; other worldly. Not used in this sense to refer to organized religion but rather to the spirits or supernatural.
SUPERNATURAL	Refers to something or some phenomena that is controlled or done by some force that is beyond human. In Liberia this is attributed to the occult or forces beyond god, the church, humans or natural laws.
SUPPORT	Refers to the assistance, help or aid given by one person to another specifically related to that assistance given to a pregnant woman during her pregnancy or labor. To give active encouragement, help or money during times of need in a pregnancy.
SYMPTOMS	Refers to the translation given by a family member, community member or traditional healer of symptoms or events a pregnant woman experiences.
TABOO	Refers to one knowing about something related to pregnancy but being forbidden to talk about it or share the information with others; another form of secrecy.
TIME	Refers to how one spends the day.

TRADITION	Refers to parts of the culture that are passed from one person to another or one generation to another specifically those related to pregnancy and childbirth. A long-established action or pattern of behavior in a community or group of people.
TRUST	Refers to a feeling of comfort/belief in your provider or your treatment. Not being afraid when in your surroundings. Feeling at ease. Understanding what is going on around you.
UNDERSTANDING	Refers to how one views the world and grasps the meaning of events related to the normal processes of pregnancy and childbirth. A person's knowledge of pregnancy and childbirth.
UNFAMILIAR	Refers to not understanding routines or procedures in the hospital or clinic environment or not having knowledge related to normal events surrounding pregnancy or childbirth.
WAR	Refers to how the war has influenced current life in Liberia. Often relates to or describes how things have changed since the war.
WITCHCRAFT	Refers to supernatural powers that influence, predict or effect events. The influence or effect of magical powers. A belief in the supernatural.

REFERENCES

- Abdoulaye, D. (2006). Maternal mortality in Africa. *The Internet Journal of Health*, 5(1). Available at: www.ispub.com Accessed July 4, 2007.
- AbouZahr, C. (2003). Safe motherhood: a brief history of the global movement 1947-2002. *British Medical Bulletin*, 67, 13-25.
- Adams, V., Miller, S., Chertow, J., Craig, S., Samen, A. & Varner, M. (2005). Having a “safe delivery”: conflicting views from Tibet. *Health Care for Women International*, 26, 821-851.
- Aday, L. A. (2001). *At risk in America: The health and health care needs of vulnerable populations in the United States* (2nd ed.). San Francisco, California: Jossey-Bass A Wiley Company.
- African Charter on Human and Peoples’ Rights (1986). Available at: http://www.africa-union.org/official_documents/Treaties_%20Conventions_%20Protocols/Banjul%20Charter.pdf Accessed December 4, 2007.
- African Commission on Human and Peoples’ Rights (2003). Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa. Available at: http://www.achpr.org/english/info/women_en.html Accessed December 4, 2007.
- Almedom, A., Tesfamichael, B., Yacob, A., Debretsion, Z., Teklehaimanot, K., Beyene, T., Kuhn, K. & Alemu, Z. (2003). Maternal psychosocial well-being in Eritrea: application of participatory methods and tools of investigation and analysis in complex emergency settings. *Bulletin of the World Health Organization*, 81(5), 360-366.
- American College of Healthcare Executives (2007). Key industry facts: 2007. *Healthcare Executive*, 22(5), (Suppl.1), 1-4.
- Amooti-Kaguna, B. & Nuwaha, F. (2000). Factors influencing choice of delivery sites in Rakai district of Uganda. *Social Science & Medicine*, 50, 203-213.
- Amowitz, L., Kim, G., Reis, C., Asher, J. & Iocopino, V. (2004). Human rights abuses and concerns about women’s health and human rights in southern Iraq. *JAMA*, 291(12), 1471-1479.
- Amowitz, L., Reis, C. & Iacopino, V. (2002). Maternal mortality in Herat province, Afghanistan, in 2002: an indicator of women’s human rights. *JAMA*, 288(10), 1284-1291.
- Anderson, E. (1995). Feminist epistemology: an interpretation and a defense. *Hypatia*, 10(3), 51-83.
- Anderson, G. (1989). Critical ethnography in education: origins, current status, and new directions. *Review of Educational Research*, 59(3), 249-269.

- Armbruster, H. (2007). Feminist theories and anthropology. Available at: <http://lit.polylog.org/2/eah-en.htm> Accessed June 19, 2007.
- Aschengrau, A. & Seage, G. (2008). *Essentials of epidemiology in public health* (2nd ed.). Sudbury, MA: Jones & Bartlett Publishers.
- Awosa-Omorodion, F. (1997). Women's perceptions of the complications of pregnancy and childbirth in two Esan communities, Edo state, Nigeria. *Social Science & Medicine*, 44(12), 1817-1824.
- Bent, K. (1993). Perspectives on critical and feminist theory in developing nursing praxis. *Journal of Professional Nursing*, 9(5), 296-303.
- Berry, N. (2006). Kaqchikel midwives, home births, and emergency obstetric referrals in Guatemala: contextualizing the choice to stay home. *Social Science & Medicine*, 62, 1958-1969.
- Boyle, J.S. (1994). Styles of ethnography. In J.M. Morse (Ed.). *Critical issues in qualitative research methods* (pp.159-185). Thousand Oaks, CA: Sage Publications, Inc.
- Boyle, J. & Bunting, S. (1998). Horsemen of the apocalypse: lessons from the gulf war. *Advances in Nursing Science*, 21(2), 30-41.
- Brislin, R. (1970). Back-translation for cross-cultural research. *Journal of Cross-cultural Psychology*, 1(3), 187-216.
- Bruni, N. (1995). Reshaping ethnography: contemporary postpositivist possibilities. *Nursing Inquiry*, 2, 44-52.
- Brunt, L. (1999). Thinking about ethnography. *Journal of Contemporary Ethnography*, 28(5), 500-509.
- Bullough, C., Meda, N., Makowiecka, K., Ronsmans, C., Achadi, E. & Hussein, J. (2005). Current strategies for the reduction of maternal mortality. *BJOG: an International Journal of Obstetrics and Gynaecology*, 112, 1180-1188.
- Bunch, C. (1993). Prospects for global feminism. In A. Jagger & P. Rothenberg (Eds.), *Feminist frameworks*. 2nd ed. New York: McGraw-Hill.
- Cain, J.M. (2000). A global overview of ethical issues in women's health. *International Journal of Gynecology and Obstetrics*, 70, 165-172.
- Callister, L. (1995). Cultural meanings of childbirth. *JOGNN*, 24(4), 327-330.
- Callister, C. & Vega, R. (1996). Giving birth: Guatemalan women's voices. *JOGNN*, 27, 289-295.
- Chapman, R. (2006). Chikotsa – secrets, silence, and hiding: social risk and reproductive vulnerability in central Mozambique. *Medical Anthropology Quarterly*, 20(4), 487-515.

- Chin, P. & Kramer, M. (2004). *Integrated knowledge development in nursing* (6th ed). St. Louis MO: Mosby.
- Cho, M. & Rose, S. (2007). Students in research. *Collaborative Institutional Training Initiative*. Available at: <http://www.citiprogram.org> Accessed December 8, 2007.
- Collins, P. (2000). *Black feminist thought: knowledge, consciousness, and the politics of empowerment*. (2nd ed.). New York: Routledge.
- Cook, K. (2005). Using critical ethnography to explore issues in health promotion. *Qualitative Health Research*, 15(1), 129-138.
- Cook, R. & Dickens, B. (2002). Human rights to safe motherhood. *International Journal of Gynecology & Obstetrics*, 76, 225-231.
- Costello, A., Azad, K. & Barnett, S. (2006). An alternative strategy to reduce maternal mortality. *The Lancet*, 368, 1477-1479.
- Crotty, M. (2003). *The foundations of social research: meaning and perspective in the research process*. London: Sage Publications, Inc.
- Daviss, B. (1997). In Robbie Davis-Floyd & Carolyn Fishel Sargent, *Childbirth and authoritative knowledge: cross-cultural perspectives*. Berkeley, CA: University of California Press.
- Delor, F. & Hubert, M. (2000). Revisiting the concept of 'vulnerability'. *Social Science & Medicine*, 50, 1557-1570.
- Denzin, N. (1997). *Interpretive ethnography: ethnographic practices for the 21st century*. Thousand Oaks, CA: Sage Publications, Inc.
- Denzin, N. (1999). Interpretive ethnography for the next century. *Journal of Contemporary Ethnography*, 28(5), 510-519.
- Denzin, N. (2003). *Performance ethnography: Critical pedagogy and the politics of culture*. Thousand Oaks, CA: Sage Publications, Inc.
- Denzin, N. & Lincoln, Y. (2005). *The sage handbook of qualitative research*. (3rd ed.). Thousand Oaks, CA: Sage Publications, Inc.
- Dudgeon, M. & Inhorn, M. (2004). Men's influence on women's reproductive health: medical anthropological perspectives. *Social Science & Medicine*, 59, 1379-1395.
- ELCA (2006). The ELCA Liberia Support Network. Available at: <http://www.elca.org/liberia/news/phebe2006update-3-07.html> Accessed December 11, 2007.
- Ellis, S. (2007). *The mask of anarchy*. (2nd ed.). Washington Square, NY: New York University Press.
- Ellsberg, M. (2006). Violence against women and the millennium development goals: facilitating women's access to support. *International Journal of Gynecology & Obstetrics*, 94, 325-332.

- Emerson, R.M., Fretz, R.I. and Shaw, LL. (eds). (1995). *Writing Ethnographic Fieldnotes*. Chicago: The University of Chicago Press.
- Fathalla, M. (2006). Human rights aspects of safe motherhood. *Best Practice & Research Clinical Obstetrics and Gynaecology*, 20(3), 409-419.
- Fillippi, V., Ronsmans, C., Gohou, V., Goufodji, S., Lardi, M., Sahel, A., Saizonou, J. & DeBrouwere, V. (2005). Maternity wards or emergency obstetric rooms? Incidence of near-miss events in African hospitals. *Acta Obstetrica et Gynecologica Scandinavica*, 84(1), 11-16.
- Fillippi, V., Ronsmans, C., Campbell, O., Graham, W., Mills, A., Borghi, J., Koblinsky, M. & Osrin, D. (2006). Maternal health in poor countries: the broader context and a call for action. *The Lancet*, 368, 1535-1541.
- Flaskerud, J. & Winslow, B. (1998). Conceptualizing vulnerable populations health related research. *Nursing Research*, 47(2), 69-78.
- Fontana, A. & Frey, J. (2007). The Interview: From Neutral Stance to Political Involvement. In N.K. Denzin & Y.S. Lincoln (Eds.). *The sage handbook of qualitative research* (3rd ed., pp.695-728). Thousand Oaks, CA: Sage Publications, Inc.
- Fransen, L. (2003). The impact of inequality on the health of mothers. *Midwifery*, 19, 79-81.
- Freedman, L.P. (2001). Using human rights in maternal mortality programs: from analysis to strategy. *International Journal of Gynecology and Obstetrics*, 75, 51-60.
- Gottschall, J. (2004). Explaining wartime rape. *The Journal of Sex Research*, 41(2), 129-136.
- Graham, W. & Hussein, J. (2007). Minding the gaps: a reassessment of the challenges to safe motherhood. *American Journal of Public Health*, 97(6), 978-983.
- Hall, J. & Stevens, P. (1991). Rigor in feminist research. *Advances in Nursing Science*, 13(3), 16-29.
- Hammersley, M. & Atkinson, P. (2007). *Ethnography: principles and practice*. (3rd ed.). London: Routledge.
- Hardcastle, M., Usher, K., & Holms, C. (2006). Carspecken's five-stage critical qualitative research method: an application to nursing research. *Qualitative Health Research*, 16(1), 151-161.
- Hilton, A. & Skrutkowski, M. (2002). Translating instruments into other languages: development and testing processes. *Cancer Nursing*, 25(1), 1-7.
- Hooks, b. (2000). *Feminist theory: from margin to center*. (2nd ed.). Cambridge: South End Press.

- Igreja, V., Kleijn, W. & Richters, A. (2006). When the war was over, little changed: women's posttraumatic suffering after the war in Mozambique. *The Journal of Nervous and Mental Disease*, 194(7), 502-509.
- International Confederation of Midwives (2006). Guidelines for ethical research collaboration across international and culturally diverse communities. The Hague: International Confederation of Midwives. *Journal of Midwifery and Women's Health*, 51(4), 311-312.
- International Rescue Committee (2004). *Situation analysis of gender-based violence in Liberia*. International Rescue Committee: New York.
- Jensen, I. (2006). Decision making in childbirth: the influence of traditional structures in a Ghanaian village. *International Nursing Review*, 53, 41-46.
- Jordan, B. (1997). In Robbie Davis-Floyd & Carolyn Fishel Sargent, *Childbirth and authoritative knowledge: cross-cultural perspectives*. Berkeley, CA: University of California Press.
- Kaiser Foundation (2007). Available at: <http://www.kff.org/insurance/snapshot/chcm010307oth.cfm> Accessed October 11, 2007.
- Karnieli-Miller, O., Strier, R. & Pessach, L. (2009). Power relations in qualitative research. *Qualitative Health Research*, 19(2), 279-289.
- Klarlc, M., Klarlc, B., Stevanovic, A., Grkovic, J. & Jonovska, S. (2007). Psychological consequences of war trauma and postwar social stressors in women in Bosnia and Herzegovina. *Croatian Medical Journal*, 48, 167-176.
- Krantz, G. & Garcia-Moreno, C. (2004). Violence against women. *Journal of Epidemiology & Community Health*, 59, 818-821.
- Krug, M., Prescott, M. & Galea, S. (2008). Equity of skilled birth attendant utilization in developing countries: financing and policy determinants. *American Journal of Public Health*, 98(1), 142-147.
- Lauderdale, J. (2003). Transcultural perspectives in childbearing. In M. Andrews & J.S. Boyle (Eds.), *Transcultural concepts in nursing care* (pp. 95-131). Philadelphia: Lippincott.
- Liamputtong, P., Yimyam, S., Parisunyakul, S., Baosoung, C. & Sansirihun, N. (2005). Traditional beliefs about pregnancy and child birth among women from Chiang Mai, northern Thailand. *Midwifery*, 21, 139-153.
- Liberia Institute of Statistics and Geo-Information Services (LISGIS) [Liberia], Ministry of Health and Social Welfare [Liberia], National AIDS Control Program [Liberia], and Macro International, Inc. (2008). *Liberia Demographic and Health Survey 2007*. Monrovia, Liberia: Liberia Institute of Statistics and Geo-Information Services (LISGIS) and Macro International.

- Leininger, M. (1997). Overview of the theory of culture care with the ethnonursing research method. *Journal of Transcultural Nursing*, 8(2), 32-52.
- Lincoln, Y. & Guba, E. (1985). *Naturalistic Inquiry*. Beverly Hills, CA: Sage Publications.
- Loncar, M., Medved, V., Javanovic, N. & Hotujac, L. (2006). Psychological consequences of rape on women in 1991-1995 war in Croatia and Bosnia and Herzegovina. *Croatian Medical Journal*, 47, 67-75.
- Lori, J. (2006). Trip report #1 – Liberia Assessment (pp. 23-33). Washington, DC: United States Agency for International Development.
- Lori, J. (2007). Trip report #4 – Complication Audits (Appendix S). Washington, DC: United States Agency for International Development.
- Lowenberg, J. (1993). Interpretive research methodology: broadening the dialogue. *Advances in Nursing Science*, 16(2), 57-69.
- MacDonald, E. & Schoenberger, C. (2007, August 30). The world's 100 most powerful women. *Forbes*, 32-40.
- Madison, S. (2005). *Critical ethnography*. Thousand Oaks, CA: Sage Publications, Inc.
- Maimbolwa, M., Yamba, B., Diwan, V. & Ransjo-Arvidson, A. (2003). Cultural childbirth practices and beliefs in Zambia. *Journal of Advanced Nursing*, 43(3), 263-274.
- McDermott, M. & Palchanes, K. (1994). A literature review of the critical elements in translation theory. *Image: Journal of Nursing Scholarship*, 26(2), 113-117.
- Morse, J.M. (1994a). Designing funded qualitative research. In N.K. Denzin & Y.S. Lincoln (Eds.) *Handbook of qualitative research* (pp. 220-274). Thousand Oaks CA: Sage Publications, Inc.
- Morse, J.M. (1994b). Emerging from the data: the cognitive processes of analysis in qualitative inquiry. In J.M. Morse, (Ed.), *Critical issues in qualitative research methods* (pp.23-43). Thousand Oaks CA: Sage Publications, Inc.
- Munhall, P. (2001). *Nursing research: a qualitative perspective*. (3rd ed.). Mississauga, Canada: Jones and Bartlett Publishers Canada.
- Munhall, A. (2003). In the field: notes on observation in qualitative research. *Journal of Advanced Nursing*, 41(3), 306-313.
- Murphy, F. (2005). Preparing for the field: developing competence as an ethnographic field worker. *Nurse Researcher*, 12(3), 52-60.
- Obaid, T. (2007). No woman should die giving life. *The Lancet*, 370, 1287-1288.
- Okafor, C. (2000). Folklore linked to pregnancy and birth in Nigeria. *Western Journal of Nursing Research*, 22(2), 189-202.

- Olesen, V. (2005). Early millennial feminist qualitative research. In N. K. Denzin & Y. S. Lincoln, (Eds.), *The handbook of qualitative research* (3rd ed., pp.220-274). Thousand Oaks CA: Sage Publications, Inc.
- PATH (2005). Available at: http://www.rho.org/html/sm_overview.htm Accessed November 24, 2007.
- Parker, B. & McFarlane, J. (1991). Feminist theory and nursing: an empowerment model for research. *Advances in Nursing Science*, 13(3), 59-67.
- Penrod, J., Preston, D., Cain, R. & Starks, M. (2003). A discussion of chain referral as a method of sampling hard-to-reach populations. *Journal of Transcultural Nursing*, 14(2), 100-107.
- Purdy, I. (2004). Vulnerable: a concept analysis. *Nursing Forum*, 39(4), 25-33.
- Qualis Research (2008). Ethnograph (Version 6.0) [Computer Software]. Colorado Springs, CO: Qualis Research. Available at: <http://www.qualisresearch.com/default.htm> Accessed May 12, 2008.
- Queenan, J. (2007). Taking aim at poverty. *Obstetrics and Gynecology*, 110(5), 968-969.
- Reef, C. (2002). *This our dark country: the American settlers of Liberia*. New York: Houghton Mifflin Co.
- Ronsmans, C. & Graham, W. (2006). Maternal mortality: who, when, where, and why. *Lancet: Maternal Survival*, September: 13-24.
- Rosenfield, A., Maine, D. & Freedman, L. (2006). Meeting MDG-5: an impossible dream. *Lancet: Maternal Survival*, September: 5-6.
- Roth, D. & Mbizvo, M. (2001). Promoting safe motherhood in the community: the case for strategies that include men. *African Journal of Reproductive Health*, 5(2), 10-21.
- Safe Motherhood (2007). Available at: <http://www.safemotherhood.org>. Accessed June 3, 2007.
- Sandelowski, M. & Barroso, J. (2003). Writing the proposal for a qualitative research methodology project. *Qualitative Health Research*, 13(6), 781-820.
- Shaw, D. (2006). Women's right to health and the millennium development goals: promoting partnerships to improve access. *International Journal of Gynecology and Obstetrics*, 94, 207-215.
- Sibley, L. & Sipe, T. (2003). What can a meta-analysis tell us about traditional birth attendant training and pregnancy outcomes? *Midwifery*, 20, 51-60.
- Sideris, T. (2003). War, gender and culture: Mozambican women refugees. *Social Science & Medicine*, 38, 713-724.
- Simon, R. & Dipbo, D. (1986). On critical ethnographic work. *Anthropology & Education Quarterly*, 17, 195-202.

- Spiers, J. (2000). New perspectives on vulnerability using emic and etic approaches. *Journal of Advanced Nursing*, 31(3), 715-721.
- Spradley, J. (1979). *The Ethnographic Interview*. New York: Holt, Rinehart and Winston.
- Stewart, A. (2000). *Toward a feminist strategy for studying women's lives*. Thousand Oaks, CA: Sage Publications.
- Swiss, S., Jennings, P., Aryee, V., Brown, G., Jappah-Samukai, R., Kamara, M., Schaack, R. & Turay-Kanneh, R. (1998). Violence against women during the Liberian conflict. *JAMA*, 279(8), 625-629.
- Tavara, L. (2006). Sexual violence. *Best Practice & Research Clinic Obstetrics and Gynaecology*, 20(3), 395-408.
- Thaddeus, S. & Maine, D. (1994). Too far to walk: maternal mortality in context. *Social Science & Medicine*, 38(8), 1091-1110.
- Thomas, J. (1993). *Doing critical ethnography*. Newbury Park, CA: Sage Publications, Inc.
- Tinker, A. (2000). Women's health: the unfinished agenda. *International Journal of Gynecology and Obstetrics*, 70, 149-158.
- Tong, R. (1998). *Feminist thought* (2nd ed.). Boulder, CO: Westview Press.
- UNICEF (2005). The impact of conflict on women and girls in west and central Africa and the UNICEF response. Available at: http://www.unicef.org/publications/index_25262.html Accessed February 15, 2006.
- USAID (2002). USAID/Liberia – Success stories. Available at: http://www.usaid.gov/regions/afr/success_stories/liberia.html Accessed January 29, 2009.
- Ujah, I., Aisien, O., Mutahir, J., Vanderjagt, D., Glew, R. & Uguru, V. (2005). Factors contributing to maternal mortality in north-central Nigeria: a seventeen year review. *African Journal of Reproductive Health*, 9(3), 27-40.
- United Nations (1993). Declaration on the Elimination of Violence Against Women, Available at: http://www.wunrn.com/reference/pdf/Elimination_violence_women.PDF Accessed December 3, 2007.
- United Nations (2005). *World population prospects: the 2004 revision*. New York: United Nations, Department of Economic and Social Affairs/Population Division.
- Van der Kraaij, F. (2007). Liberia Past and Present of Africa's Oldest Republic. Available at: <http://www.liberiapastandpresent.org/> Accessed November 25, 2007.

- WGBH Education Foundation (2002). Available at:
<http://www.pbs.org/wgbh/globalconnections/liberia/essays/history/> Accessed November 24, 2007.
- WHO (1992). *International Classification of Diseases and Related Health Problems*, 10th ed. Geneva: World Health Organization.
- WHO (2003). *Working with individuals, families and communities to improve maternal and newborn health*. Making Pregnancy Safer Initiative, Reproductive Health and Research: Geneva.
- WHO (2004). Available at:
http://www.who.int/hac/crises/lbr/background/2004/Liberia_Nov04.pdf
 Accessed May 24, 2007.
- WHO (2006a). Mortality Country Fact Sheet. Available at:
http://www.afro.who.int/home/countries/fact_sheets/liberia.pdf Accessed September 11, 2007.
- WHO (2007a). Core Health Indicators. Available at: <http://www.who.int/whosis/en/>
 Accessed October 9, 2007.
- WHO (2007b). The Sisterhood Method for Estimating Maternal Mortality. Available at:
http://whqlibdoc.who.int/hq/1997/WHO_RHT_97.28.pdf Accessed December 3, 2007.
- WHO (2008). Eliminating female genital mutilation. Available at:
http://who.int/reproductive-health/publications/fgm/fgm_statement_2008.pdf
 Accessed January 29, 2009.
- Watchlist (2004). Children and Armed Conflict/Women's Commission for Refugee Women and Children (2004). *Nothing left to lose: the legacy of armed conflict and Liberia's Children*. Available at:
<http://www.watchlist.org/reports/pdf/liberia.report.pdf> Accessed February 15, 2006.
- Wilkinson, R. (2006). Ourselves and others – for better or worse: social vulnerability and inequality. In M. Marmot & R. Wilkinson, (Eds.), *Social Determinants of Health* (2nd ed., pp.341-357). New York: Oxford University Press, Inc.
- Wilson, H. S. (1989). *Strategies of field research* (2nd ed.). Redwood City, California: Addison-Wesley Publishing Company.
- World Languages (2007). Liberian Tribal Languages. Available at:
<http://www.worldlanguage.com/Languages/Kpelle.htm> Accessed December 15, 2007.
- World Medical Association (2003). The World Medical Association Statement on Female Genital Mutilation. Available at: <http://www.wma.net/e/policy/c10.htm>
 Accessed February 9, 2009.

Yanda, K., Smith, S. & Rosenfield, A. (2003). Reproductive health and human rights.
International Journal of Gynecology & Obstetrics, 82, 275-283.