Exploring the forgotten variable: Engaging, Listening, & Learning From Apostolic Traditional Birth Attendants

Study Findings Presentation
Presented by: Karen Webb, OR Director, OPHID Trust
UNICEF Zimbabwe Brown Bag, August 26th, 2014
Context

• OPHID Trust Operational Research Study

• Supported through CCORE/UNICEF small grant

• Led by OPHID volunteer, nurse practitioner - Andrew McLellan, MScN, PHC-NP

• Building on:
  • OPHID Operational Research and Program Observations:
    o Home Delivery in Mashonaland Central
    o Engagement with Traditional Health Providers for PMTCT
  • UNICEF research:
    o Equity and Maternal and Child Health - Is Religion the Forgotten Variable? Evidence from Zimbabwe
    o Apostolic Religion, Health, and Utilization of Maternal and Child Health Services in Zimbabwe
Background

- **Non-institutional delivery**: ↑ Risk of maternal and neonatal mortality, MTCT of HIV
- Membership to Apostolic faith predictor of **non-use of maternal healthcare** services in Zimbabwe.
- In Zimbabwe 38% of women identify as Apostolic (2010/11 ZDHS).
- **Some** Apostolic groups have developed their own healthcare system.
- **Apostolic Traditional Birth Attendants (AtBAs)** provide maternal healthcare services
- Little known about the practices or beliefs of AtBAs in Zimbabwe.
The aim of this research was to explore the institutional arrangements, knowledge, practices, and accountability of AtBAs.

Research Objectives:
1. To explore the institutional arrangements of the practice of AtBAs;
2. To identify the process and procedures employed by AtBAs in the care of women during pregnancy, childbirth and the postnatal period;
3. To identify and offer insight into existing assets and needs in regards to the care provided by AtBAs;
4. To provide clear recommendations for possible further intervention/collaboration and to articulate lesson learnt.
Methods

- **Exploratory qualitative study** conducted in Mashonaland Central Province between March 2013 and Dec 2013.

- Theoretical underpinnings were derived from **harm reduction theory** and **appreciative inquiry**.
Research Procedures

1. Research team in collaboration with DHA conducted a mapping exercise of known AtBAs for each district (N=37)
2. AtBAs are selected from each District (Marange and Masowe)
3. District Community Nurse accompanies the research team to the AtBAs homestead for introduction, and sensitisation of the research
4. AtBA accepts or declines to participate in the study
5. Accepted: Date agreed upon for the research team to return to the AtBAs homestead
6. Research team returns to AtBAs homestead, formal consent process completed, number of days stay agreed upon, compensation list completed.
7. Research team stay for agreed upon number of days and data collection period begins.
8. Research team joins in the life of homestead, and complete data collection (observational/vignettes/interviews)
9. The research team is collected and compensation materials are provided to the AtBA
10. Upon return from the field the research team conducts a debriefing meeting.
Data Collection Tools

• **Semi-structured interviews:** institutional arrangements, knowledge, practice, accountability and willingness for collaborations with the formal healthcare system.

• **Story telling vignettes of complications:** antenatal/intrapartum/postpartum periods

• **Non-participatory observation:** throughout field work for interpretive depth.

• **Two key informant interviews** were conducted with mid-level church leaders from both the Johanne Marange and Johanne Masowe groups.
Example of Story Telling Vignette

Fungai is breastfeeding her new baby, who was born five hours ago. When Fungai stands up, blood and clots run down her legs onto the ground. Her clothes are very soaked with blood.

*Ask*, Can you think of at time you may have seen a woman who was bleeding too much after the baby was born? *If yes, ask:*

- What did you see? *(signs)*
- What did you do to help the woman? *(action)*
- What happened to the woman? *(outcome)*
- What can cause a woman to bleed too much after the baby is born? *(cause)*
• **Masowe and Marange** AtBAs distinguished in terms of belief and practice.

• **Thematic content analysis** grouped separately for further *between- and within-group analysis* of key themes:
  1. Institutional arrangements
  2. AtBA Practices
  3. Willingness to collaborate with formal health system
  4. Payment received for AtBA services
Limitations

- Exploratory qualitative study
- First step in understanding
- Engagement process as important as findings
- Small sample – case study approach
- **Not generalizable** by Apostolic group or by AtBA practice
Findings: Research Procedures

- **Little known about location and practices.**

- **Snowballing referral** by AtBAs: #s AtBAs greater than identified by health care workers.

- **Greater collaborative engagement** by health authorities = more known AtBAs

<table>
<thead>
<tr>
<th>District</th>
<th>Number AtBAs Identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mazowe</td>
<td>5</td>
</tr>
<tr>
<td>Shamva</td>
<td>3</td>
</tr>
<tr>
<td>Centenary</td>
<td>2</td>
</tr>
<tr>
<td>Mbire</td>
<td>3</td>
</tr>
<tr>
<td>Mt. Darwin</td>
<td>2</td>
</tr>
<tr>
<td>Rushinga</td>
<td>3</td>
</tr>
<tr>
<td>Guruve</td>
<td>5</td>
</tr>
<tr>
<td>Bindura</td>
<td>14</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>37</strong></td>
</tr>
</tbody>
</table>
Findings: Belief systems

Cross-cutting beliefs:

- **Holy spirit** guiding force in faith healing
- **Witchcraft/evil spirits** role in ill health
- **Visions** guided by Holy Spirit
- **Prayer and holy water** for healing
- **Cleansing** as route to healing/good health
- **Spiritual health primary; physical secondary**
Findings: Belief systems

On Holy Spirit as guiding force in Apostolic faith healing...

“We have spiritual guidance. The Holy Spirit shows us the problems and provides solutions to problems”.

““This is a spiritual thing if you believe in something it happens. Its faith-based”.”
Findings: Institutional Arrangements

SIMILARITIES....

Both groups:

• AtBAs run birth camps/conduct deliveries at their home

• Organisational structures consists of prophets, healers, preachers and baptizers. AtBAs are primarily considered healers within this structure.

• AtBA appointment made by Holy Spirit

• No formal medical training required

• AtBAs share information about practices

“Training is not necessary as I am a prophet and I get my inspiration from God himself”. 
and DIFFERENCES....

Marange AtBAs:
- **Hierarchical** leadership structure: church leaders at local, district, provincial and national levels
- **No formal training** reported
- **No use of medication or referral** to formal health services

Masowe AtBAs:
- More **decentralised** leadership structure
- Described receiving **formal training in 80s/90s**
- AtBAs appear to be more **self-deterministic**
- **Pluralistic utilisation** of Apostolic and biomedical health services
Findings: Practice and Provision of Care

AtBA ‘cascade of care’ approximates that of biomedical health system in form and services.
### Findings: Managing Complications

<table>
<thead>
<tr>
<th>Complication</th>
<th>Both Masowe and Marange AtBAs</th>
<th>Masowe AtBA</th>
<th>Marange AtBAs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnosis</strong></td>
<td>✓ Scans with hands over abdomen ✓ Visions</td>
<td>✓ Consult client-held health cards</td>
<td>✓ Knowledge from historical health care training</td>
</tr>
<tr>
<td><strong>Cause</strong></td>
<td>✓ Evil spirits/witchcraft</td>
<td>✓ Infidelity/promiscuity</td>
<td>✓ Biological problems (bacteria, virus)</td>
</tr>
<tr>
<td><strong>Treatment</strong></td>
<td>✓ Prayer ✓ Holy water</td>
<td>✓ Confession of sins</td>
<td>✓ Medicine ✓ Referral to health facility</td>
</tr>
</tbody>
</table>
Findings: Infection Control

- **Standard household equipment** used (buckets, blankets, razor, water)

- **Limited knowledge of infection control procedures**
  - Bare hands used for internal exams
  - Same bowl of water used to wash hands repeatedly during procedures and after delivery

- **Observational checklists of delivery area** indicated **standard precaution equipment not available** – what is available not sterile

**Standard Precautions and Cleanliness:**
- wash hands
- wear gloves
- protect yourself from blood and other body fluids during deliveries
- practice safe sharps and waste disposal
- deal with contaminated laundry
- sterilize and clean contaminated equipment
- clean and disinfect gloves
- sterilize gloves

WHO, Integrated Management of Pregnancy and Childbirth (IMPAC) described in Appendix A
Findings: Willingness to Collaborate

There are similarities and differences in willingness of AtBAs to collaborate with formal health system.

<table>
<thead>
<tr>
<th>Both Marange and Masowe AtBAs</th>
<th>Masowe AtBAs</th>
<th>Marange AtBAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Preference to meet with health officials in community vs. at clinic</td>
<td>✓ Willing to accompany women to clinic</td>
<td>✓ Only with permission of church leaders</td>
</tr>
<tr>
<td>✓ Will accept infection control equipment</td>
<td>✓ Refer to clinic when spiritual healing unresponsive/condition worsening</td>
<td></td>
</tr>
<tr>
<td>✓ Willingness to receive training/information</td>
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Findings: Assets and Needs of AtBAs

Assets:
• Holistic care
• Acceptable care
• Care to most vulnerable women
• Dialogue welcome
• Positive practices to build on (referral, collaboration)

Needs:
• Less antagonism and more collaboration
• “Apostolic friendly health services” – free of judgment, respecting boundaries
• Missed opportunities for harm reduction
• Improved notification systems – birth & death
• Poverty alleviation
• Support for most vulnerable women and children to overcome key barriers: knowledge, fees, distance, social support
• Inclusive inter-faith approaches rather than ‘interventions targeting Apostolics’

“Most do not have a blanket to cover themselves in the homes they come from. When she comes to maternity you will take your children’s blankets because you cannot leave her with nothing.”
Recommendations

Short game: **Reduce Harm**

Interim **evidence-based, feasible, low-cost interventions** that can save maternal and neonatal lives should be undertaken in the short term.

- Care of **pre-term infants**
- Maintaining the **warm chain**
- Promotion of **exclusive breastfeeding**
- **Cord care**
- **Clean delivery** – use of standard precautions
- **Infection control** in context of HIV
Mid Game: **Revisiting modes of referral, advocacy and collaboration**

- Increase *engagement* with AtBAs
- **Collaboration strategies** between Apostolic and formal health care systems
- Strengthening *community-based referral networks* (AtBAs, village health workers)
- Identify and build on *positive practice*
- Improve *healthcare worker attitudes*
Recommendations

Long Game: Acceptable behaviour change

Behaviour change communication for collaborative efforts to improve maternal and child health:

- **High level engagement** with Apostolic leadership
- **Rights-based** approaches
- **Strengthening culture and people** rather than changing belief systems
- **Document and share positive deviance**: uncommon, practical and effective ways improving MNCH that brings advantage to Apostolic communities
Recommendations

Research process: lessons to move forward

- **Non-judgemental** collaboration
- **Ethnographic** approach – less polarisation more mutual understanding
- **Context is key**: generalizability not feasible, or desirable
- **Questionable value of ‘large scale’ research** with heterogeneous populations
- **Framework of engagement** deserves further study in context
1. Engage with relevant Apostolic leaders where possible.

2. Work with local health authorities to approve activity and plan initial site visit.

3. Initial site visit to Apostolic community: describe purpose of activities and arrange time/place for return visit.

4. Return on proposed date, with focused dialogue plan (not 'teaching' curriculum).

5. Facilitate dialogue on topic providing health information, and allowing Apostolic community discussion of acceptable solutions to this public health issue.

6. Focus on incremental gains and strengthening referrals and collaboration as opposed to major changes in practice.

7. Set acceptable action points. Allow community to choose discussion topic and date for next visit.
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An Exploratory Qualitative Study of the Role of Apostolic Midwives in Mashonaland Central Province, Zimbabwe
September 2014

Ministry of Health and Child Care
UNICEF Zimbabwe
Collaborating Centre for Operational Research and Evaluation (CCORE) Reference Group
PEPFAR through USAID
Apostolic traditional birth attendants and leaders who participated in this research

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