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The Professional Role of Skilled Birth Attendants' in Nepal-

A Phenomenographic Study

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Abstract

Objective: The aim of this study was to describe the Nepali Skilled Birth Attendants' (SBAs) perceptions of their professional role.

Methods: Fifteen Nepalese SBAs were interviewed using a semi-structured interview guide. A phenomenographic approach was chosen to describe their qualitatively different and unreflective conceptions of the professional role. Data was analysed in a seven-step process and three description categories and six conceptions emerged.

Results: The SBAs described *the role as provider, the role as counsellor* and *the role as educator.* As provider, the SBA maintained midwifery nursing and prevented maternal deaths. As counsellor, the SBA advocated and empowered women and facilitated family planning. As educator, the SBA promoted health of families and health in the society. She also tutored students and colleagues about skills and human rights.

Conclusion: The SBAs' vulnerability emerged especially in rural areas while preventing complications and newborn and maternal death in rural areas where she often worked alone with lack of proper equipment and access to other medical professionals. The SBAs perceived that their professional roles required knowledge and experiences, were safety was closely linked to health education. Ethical dilemma could arose when they had to relate to the families' cultural decisions. Education was a key factor connected to close life-saving

procedures and to retain good quality and safety in newborn and maternal healthcare. The SBAs switched between their three roles, always striving to be aware of compliance with the Sustainable Development Goals policy.

Keywords: Vulnerability, education, Nepalese culture, skilled birth attendant

Introduction

Well-trained midwives save lives and prevent roughly two thirds of all maternal and newborn deaths. They are also responsible for 87 per cent of all essential sexual, reproductive, maternal and newborn health services [1]. Globally, approximately 830 women die daily from preventable causes related to pregnancy and childbirth [2]. The causes are mostly obstetric haemorrhages connected to delivery, followed by sepsis and complications, unsafe abortions and indirect infections related to HIV [3]. Furthermore, almost one hundred per cent of all maternal deaths occur in developing countries and amongst women living in rural areas with poor living conditions [2]. Nepal, with approximately 593 000 live births a year, has less than 60% skilled attendants present at birth. The Maternal Mortality Rate (MMR) is 239 maternal deaths for every 100 000 live births according to the Nepalese Population and Health Survey [4]. The Millennium Development Goals (MDGs), valid from 2000 to 2015, were intended to support developing countries in the field of midwifery which strived to reduce child mortality and improve maternal health [5]. Significant achievements have been seen over the last decades in the MDG targets, e.g. better access to sexual and reproductive healthcare, access to safe abortions and reduction in maternal and child mortality [6]. The Government of Nepal passed a new abortion act, in 2002, to ensure safe abortions in collaboration with non-governmental organisations, and to support staff in abortion care with information and

adequate training. Reproductive healthcare in Nepal integrates abortion care and contraceptive services and will be available nationwide and free of charge to deprived and marginalised women [7]. The MDG's successor consists of the Sustainable Development Goals (SDG) which claim universal healthcare and the aim is to reach the targets by 2030. Relevant targets apart from sexual and reproductive health are to achieve gender equality, empower all women and girls and reduce inequalities [8].

Traditions in Nepal

Traditions shape the role of women world-wide, also in Nepal, and influence reproductive health issues, views on sexuality, contraceptives and childbearing. By law, the caste system is prohibited, however it is still present in Nepalese society. Traditions are influenced by both Hinduism and Buddhism, the patriarchal structure which affects women and minority groups in particular [9]. More than half of the women in Nepal are married by eighteen years of age [4], usually with someone of their own caste and ethnic group [10]. In traditional Nepalese families, the mother-in-law is responsible for the traditions associated with health issues including childbearing. It is a contextual imperative to bear children and childbirth is appreciated in the family, especially if it is a boy, who is seen to possess divine power [11]. In remote areas, the concept of 'birth pollution' is a traditional construction, where women and family members believe their health is threatened by family deities, since 'all exudates from the body' are spiritually unclean [12]. Accordingly, giving birth in the cow shed is seen as a necessity to prevent 'birth pollution'. The seclusion of women to a cow shed during and after birth is considered to create a risk of infection leading to higher maternal mortality [13]. Milne et. al. (2015) states that the socio-cultural context in developing countries constrain women from accessing medical services. Despite the fact that the number of institutional births is increasing in Nepal, many women still give birth at home with assistance from family and women experienced

in childbirth. There are major obstacles that delay women giving birth to reach health care on time. For example, lack of knowledge of health care services and lack of autonomy for women [14].

The role of the midwife

The International Confederation of Midwives (ICM) states that midwives work in partnership with the family, with respect for human dignity and human rights, promoting the health of mothers, newborns and families. A midwife's further focus is on disease prevention, with emphasis on cultural sensitivity including advocacy against harm towards women and newborns [15]. Cheung et al [16] stress that a strong midwifery workforce brings benefits by contributing to the advancement of gender equality and women's rights. The practice of midwifery demands skilled, knowledgeable and compassionate care for childbearing women, newborns and families. Core characteristics include optimising the biological, psychological, social and cultural processes of reproduction and early life. In addition, the appropriate prevention and management of life-threatening obstetric complications, consultations with and referral to other services, respecting women's individual circumstances and views. Furthermore, midwifery also includes working in partnership with women to strengthen their ability to care for themselves and their families [17]. Midwifery in Nepal does not have a professional independent status according to the standards of ICM [18]. The Ministry of Health and Population in Nepal has set goals to develop midwifery training and leadership in maternity care [19].

In 2016 four Universities in Nepal started the Bachelor of Midwifery Education program and the first cohort of midwives' will graduate in autumn 2019 [20].

In the meantime, midwifery tasks are managed by SBAs. Knowledge of reproductive health in Nepal based on quantitative methods is extensively represented, but there is a

lack of studies with a qualitative approach from the SBAs perspective. Thus, the aim of this study was to describe the Nepali SBAs' perceptions of their professional role.

Methods

Design and method

A descriptive method with a phenomenographic approach was chosen to study qualitatively different and unreflective conceptions of the phenomenon that means the SBAs' perceptions of their professional roles in Nepal. In the phenomenographic approach, reality can be perceived from two perspectives, as conceptual thinking and unreflective thinking. In the first-order perspective, the conceptual thinking, the participant talks about a phenomenon, it is made conscious and describes what something is. The second-order perspective, the unreflective thinking, describes how something is perceived to be. It means that the participants must themselves discern the phenomenon from the whole by reflecting upon it [21]. In phenomenography, the interest is in the second-order perspective how the phenomenon is perceived and concerns individuals' conceptions of their specific reality [22). Phenomenography is substance-oriented and focuses on peoples' qualitatively different and unreflective ways of perceiving, experiencing and understanding the same phenomenon in the world around them. This search for the underlying structure of variance is the essence of phenomenography [21].

The participants

Fifteen SBAs with competence in spoken educational English were strategically chosen to ensure variation in sociodemographic and clinical characteristics with respect to sex,

age, education, experience of deliveries and maternity care. Their education level differed. Six had a three year Proficiency Certificate Level (PCL) course, which included an introduction to midwifery. Six had a Bachelor's degree in Nursing Science, where an additional two years of clinical practice were required, and three had a Master's in Nursing Science, and an extra two years of clinical practice (Table 1). All fifteen participants received a SBA course, a two-month training course focusing on the care of women and newborns during birth [19]. The Head of a Nursing campus in an urban area and the Head of a District Hospital in a rural area contacted the SBAs with information of the study.

Table 1. Socio-demographic and clinical profile of the SBAs (N= 15)

Variables		**Number**
Gender	Female	15
	Male	0
Age (range 22-52)	≤30	4
	31-40	5
	41-50	5
	≥50	1
Education	PCL*	6
	BNC*	6
	MNC*	3
Years of work experiences	1-5	6
	6-10	1
	11-20	4
	>20	4
Working in urban areas		8
Working in rural areas		7

*PCL (Proficiency Certificate Level in Nursing), BNC (Bachelor's in Nursing Science), MNC (Master's in Nursing Science)

Data collection

Data collection was conducted by the first author using a semi-structured interview guide and lasted for a five-week period in autumn 2012. Two pilot interviews were conducted with SBAs to test the relevance of the questions. One of them was deemed satisfactory and included in the analysis. Data consisted of tape-recorded interviews starting with general issues, in Nepali language, and followed by two overall questions: 'Can you describe the role of a SBA in Nepal?' and 'How do you perceive the role of being a SBA in Nepal?' To gain a deeper understanding and capture the second-order perspective according to Marton [22], the SBAs were asked to expand and clarify by answering questions like: 'How do you feel about that? What do you mean by that? Please explain further'. Questions about the MDGs were asked; 'How does the MDG targets affect your daily duties' and 'what is your opinion of the MDG targets?' The interviews were conducted in a private room in the SBAs' workplaces in Nepal and lasted 25–50 minutes. The SBAs took pride in contributing to the study and spoke freely and enthusiastically about the phenomenon in focus. The interviews were transcribed by the first author within a few days after the interviews.

Data analysis

Data analysis was conducted by the first author in cooperation with the other authors. A seven-step process according to Dahlgren and Fallsberg was applied [23]. In the first step *familiarisation,* the transcribed interviews were read several times, gaining an overview and becoming familiar with the data. In the second step *condensation*, the most significant statements related to the aim were selected. A total of 60 statements were identified. The third and fourth steps were *comparison* and *grouping*. The statements were compared to find similarities and differences in the phenomenon. Those with similar content were grouped together into six conception groups. In the fifth step *articulating*, a preliminary attempt was made to describe each group and its essence, to set specific limits between the

groups and to ensure that these were distinct and qualitatively separated. The sixth step was *labelling*; the conception groups and their contents were characterised and summarised into three description categories. Finally, in the seventh step, the description categories were compared for similarities and differences on a more abstract level called *contrasting* in order to ensure the relevance of the outcome.

Table 2. A description of the data analysis process

Statements	Conceptions	Description categories
We find the mothers' need and after that we will be ready to do everything for her	Maintaining midwifery nursing	The role as provider
The midwife is a life-saver for mother and child, we must act to decrease MMR	Preventing maternal deaths	

Ethical considerations

This study was based on the fundamental principles created in the Declaration of Helsinki, which are autonomy and informed consent [24]. Approval to perform the Minor Field Study was given by School of Health and Welfare, Jönköping University, Sweden and the Health Research Council in Kathmandu. The Head of a Nursing campus in an urban area and the Head of a District Hospital in a rural area were contacted for permission to perform the study. Informed consent with verbal and written information regarding the study was given to participants. The right to withdraw at any time without giving further

explanation was emphasised and participant confidentiality was guaranteed and informed consent was obtained from participants prior to the interviews. Quotations in the text was labelled P1-P15 (P=participant) to maintain confidentiality. The first author's pre-understanding is based on extensive experience of midwifery in Sweden and Nepal. Her knowledge of the Nepali culture, context and local language facilitated the performance of the study.

Results

Three description categories and six conceptions emerged in the analysis of the SBA's professional role in Nepal. These were: *the role as provider; the role as counsellor* and *the role as educator.* The role as provider occurred when the SBA practiced midwife nursing and prevented maternal deaths. The SBA's role was also as counsellor when she advocated and empowered women and facilitated family planning. The role as educator emerged when the SBA promoted health of family and health in the society. The SBA tutored students and colleagues about skills and human rights (Table 3).

Table 3. Description categories and conceptions of the SBAs in Nepal

Description categories	Conceptions
The role as provider	Maintaining midwifery nursing
	Preventing maternal death

The role as counsellor	Advocating and empowering the women
	Facilitating family planning
The role as educator	Promoting health of family and health in the society
	Tutoring students and colleagues

The role as provider

As provider, the SBA focused on physical, psychological, social and cultural needs when she addressed midwifery nursing. She also provided safety while preventing life threatening obstetric complications.

Maintaining midwifery nursing

The SBA stated that she provided and acted for the best outcome and view of the mother's, and newborn's survival. She was responsible for the birth process and when problems arose she made decisions on her own or in collaboration with colleagues. She conducted deliveries with confidence and worked independently, which was significant when no doctors were present. The SBA made sure that all equipment was available nearby and she was careful about hygiene.

> *'I am respected in my role and adapt to any prevailing situation…'.* P9

She took pride in her role and performance and was satisfied when the outcome was uncomplicated, and the family was happy.

'When everything ends up good I feel satisfied and happy like the mother, first she just wants us to take out the child and afterwards when they have no more pain they are lucky, and me too'. P11

When the mother was in poor health condition or regarding to cultural traditions did not want to keep the newborn because of its gender, it was hard for the SBA to remain neutral.

'Sometimes the families are grateful and sometimes angry when the woman is in a poor condition. Then it is difficult to be professional'. P9

Preventing maternal death

The SBA focused on safety, prevented complications and minimised maternal deaths. She saw herself as a lifesaver for mother and newborn, observed and identified early signs of complications and if problems arose, she tried to solve them and intervened quickly. A serious problem was postpartum haemorrhages, when she had to act in consideration of the mother's and newborn's survival.

'We take action when eclampsia occurs, and we resuscitate the child'. P5

In remote areas and in roadless land the SBA felt alone and vulnerable without proper equipment and access to other medical professionals.

'It can take about four hours traveling for patients and families to come to the hospital. They come by walking and then by buses'. P5

The SBA felt vulnerable in situations when the women sought care at a late stage of childbirth because of different obstacles that delayed arrival to health care services.

'We feel powerless when women come too late and have bleeding and child can die due to late arrival to hospital'. P6

The SBA's priority was to save lives. She had to determine whether the woman needed to be referred to a higher level of care or solve the situation by herself. It involved balancing the risks and safety of women and children.

The role as counsellor

The role as counsellor was to advocate and motivate the women and the SBA became involved in family planning, family disputes and had to attend to signs of mental ill-health.

Advocating and empowering the women

When living in extended families, in-laws had the influence over decisions about pregnancy and childbirth. When the daughter-in law needed a facilitator, listener and trustful person, outside the family, this could be the SBA. The SBA found her role to be double-edged; first, she had to listen to and counsel the family and later to witness family abuse. However, she was not authorised to act. She informed women and their extended families about legal rights regarding threats and marriage. It is hard to face when women were neglecting themselves or afraid of influencing their own lives.

> '*As a midwife I need to have a good attitude to the woman and listen to her and not blame her even if she is angry and frightened'.* P14

The SBA supported and empowered women during childbirth. She aspired for a professional attitude to the woman during labour pain. The SBA comforted the women to become secure and self-reliant. The intention of the support was to empower the woman through a positive attitude.

'Family need counselling and I recommend them to go to social service office at hospital'. P7

Facilitating family planning

In family planning, the SBA informed women and men about different choices of how to prevent unwanted pregnancies. She aimed for a professional attitude and motivated the woman to go for counselling in family planning.

'I must genuinely include a family's cultural beliefs and will always listen to the mother and stay close to her with an attitude of understanding. I practice strict privacy'. P1

The SBA 'fielded contraception' with professionalism according to the abortion act. She upgraded technical knowledge and healthcare issues related to this. Abortion was a new issue in the SBA's role and made her part of something that was not fully accepted in society.

'If the family has too many girls and no son, women make test. If test shows female, then they go for abortion'. P4

She aimed for a confidential relationship with women who had been subjected to abortions regardless of the reasons.

The role as educator

As educator, the SBA promoted health in both families and in society. She tutored students and colleagues when sharing experiences and skills.

Promoting health of family and health in the society

The SBA educated families and promoted their health, regardless of socioeconomic or caste system. Clear communication and sensitivity were needed to make everyone understand. SBA experienced that it was easier to interact with educated people, since they accepted her. It seemed to her that less educated and poor families were not receptive to information in the same way as the educated families. She aimed for an open-minded attitude when meeting families with different cultural background, also those who rely on advice from which doctors.

> *'We help during Ante Natal period, birth preparation, explain about delivery, breastfeeding, how to arrange money and transportation, we explain all things, some will listen and some not.'* P9

The SBA emphasised women's awareness of health and reproductive issues and the need for self-knowledge in women's health. She carried out home visits to encourage and prepare the family during the pregnancy.

> *'I give information and teach health education about pregnancy, register visits, tetanus and other vaccinations. I make notes on all check-ups and medical consultations'.* P2

Women in rural areas needed information about risks when giving birth far away from a hospital. The in-laws sometimes refused to take the woman to a health facility for delivery, because an evil spirit might haunt the family. Nevertheless, the SBA encouraged the women to visit an antenatal clinic for support during the pregnancy, childbirth and postnatal care.

'I provide and give proper teaching and constantly repeat my teaching'. P2

The SBA organised community teaching adapted to various environments. She provided health education in primary schools about different health issues and available healthcare services. For instance the child's immunisation programme.

'When I visit the school, I teach about life and health knowledge'. P3

Tutoring students and colleagues

The SBA served as a role model in nursing and was available to her staff and students who did their internship at the ward or at health posts. She tutored and corrected nursing students about skills and attitudes with enthusiasm. She tried to engender awareness, using a holistic view including socio-cultural issues, gender laws and human rights.

'I manage the staff with skills and experiences. As supervisor I train and inspire the students to become the best.'. P11

In team building, colleagues provided support through sharing skills and experiences. This resulted in trust, joy and positive energy.

'When new midwives come, we teach them and include them in our team. All want to become skillful'. P4

To develop professionally, the SBA needed to keep herself updated regarding new equipment and technical skills. In urban areas and bigger hospitals, there were more training possibilities and she became motivated and empowered through refresher courses and internships.

'Society needs good professionals in primary maternity care and at hospitals…on practical training we can develop the midwifery nursing and implement new things'. P11

Discussion

Midwifery in Nepal is not acknowledged as meeting the standards of ICM [15]. This study describes the role of Nepalese SBAs work in midwifery, when providing quality midwifery care in all settings. Her reality as SBA was influenced by socioeconomic and traditional barriers. A main issue for the SBA in *the role as provider* was a safe place for the women's delivery and working with a holistic approach where culture and caring issues were demanding in many ways. In everyday practical work situations, all SBAs want encourage women to get access to health services to ensure safe deliveries [10]. Women living in an extended family were unable to choose for themselves, whether they wanted to visit Ante Natal Clinic (ANC) or give birth at hospital. The in-laws had great influence in decisions relating to childbearing. In this culture, and especially in rural areas mothers-in-law are negative about their daughters-in-law seeking ANC when they themselves never did. According to Milne et al [14], the SBA is the key person and lowers barriers for the family to seek skilled care during pregnancy and visit ANC on a regular basis and give birth at hospital. The SBA's vulnerability when working alone in isolated places made them unable to act professionally to save the life of mother and newborn. In Nepal there is lack of human resources, coordination and management with equipment in remote areas [25]. In challenging situations, with shortcomings, the SBA works alone and becomes drained and sometimes her professional role is undervalued and unpaid [26]. Despite this, she demonstrates independence and confidence [10]. It is important for midwives to use strategies to maintain a sense of positive confidence. Education and leadership help to cope

with challenging situations [27] and her fatalistic cultural beliefs help her in these situations [28, 29]. Regarding cultural barriers some families primarily asked a witch doctor for advice, which often resulted in complications during pregnancy and delayed childbirth. Culturally-based traditions of childbirth conflict with SBAs' view of safety and risk [13]. As provider the SBAs are facing daily ethical challenges in healthcare practice. They had to adjust to gender selective practises and the family´s disappointment, when a girl was born. In a patriarchal society like Nepal, the man is the family decision- maker and an ethical dilemma arises for the SBA when she guide women and men in shared parenting [30]. Family roots are important, and how they relate to the cultural values of Nepal is difficult for an outsider to fully understand. These culture barriers have an impact on the SBAs' moral responsibility, and can be painful and troublesome for them [31]. It could be valuable to recommend the use of a social-ecological approach when dealing with ethical problems for SBAs in Nepal it is complex to give advice during pregnancy due to cultural differences [32]. The SBA needed to be alert about regulations and risks; she tried to act according to the scope of her professional role. The SBA was proud and strove to ensure safety and involved the woman and her cultural beliefs. Midwives are trained to provide necessary healthcare from early pregnancy, through childbirth and postnatal follow-ups to identify and manage complications and ensure referrals if emergencies arise [1]. According to Berg [33] 'the midwifery model of care for childbearing women at high risk', the professional midwife is adaptable and provides genuine care together with observations and check-ups. The strategic directions for midwives have prioritised quality, equity and leadership. Globally, every childbearing woman shall have access to midwife' care for herself and her newborn [34] and this complies with SDG goals [8].

The SBA's *role as counsellor* was to deal with contraceptive advice and topics of a private nature. Maintaining confidentiality was necessary for the SBAs when listening to

families' intimate issues and hardships due to abuse. However, they were not authorised to act. The SBA advocated legal and human rights and supported and empowered the woman to cope with the family. The women are positive that midwives asked about their relationships in the marriage and therefore the women dare to talk about difficult problems, such as psychological abuse from the husband and his in-laws [35]. The midwife's role in the Family Planning Programme is crucial [36]. One of the benefits in family planning is shown to be related to women's position in society and their decision making power to access and use of contraceptives [11]. Still there are unmet needs and differences between women living in urban and rural areas [14]. According to WHO's policy guidelines on contraception and safe abortions, the midwife arranged classes in family planning and follows the recommendations [37]. An opportunity arises to assist the couple with how to accurately plan pregnancies, the woman is the SBA's first focus and she encourages the woman's own resources, i.e. empowerment. The SBAs needed to relate to the Nepalese Abortion Act of 2002 [7], which can be a taboo topic [38]. Medical professionals are widely supportive in providing safe abortion services, which are a crucial contribution to women's health [39]. Most women are satisfied and relieved after the abortion, but others experience disrespectful care and behaviour from the providers [38]. While working with abortion care, the SBAs consider that they do what they ought to do, but sometimes they become demoralised, which can lead to reduced motivation and inefficiency [40]. The SBA's perceptions of supporting the women is two-fold; at times she listens and counsels the family and at other times she will be told about abuse in the family but is not able to act. This ethical and social dilemma may arise when meeting families, especially if they are not able to read or understand laws and conventions.

In *the role as educator,* the SBA promoted health to families and society and the results showed her willingness to teach. In every situation she used her knowledge to inspire

health awareness. Promoting health was the main issue, especially to women and families who were not accustomed to healthcare services. For the SBA dealing with educated people is not a problem, but she feels frustration when she has to communicate and share education with less educated families with no interest in health issues [26]. A Nepalese SBA puts education first, and whenever she meets a mother, she provides an educational experience for her [41]. At best mother and SBA will see each other several times [13]. It is known that low health literacy families need special instructions during communication and there is a need for midwifes to know the teach-back method. This is an evidence-based strategy and identified as a cornerstone intervention for improving communication during healthcare encounters [41]. The family needed to be target in the SBA's health education. Better knowledge about women's health, reduction of the workload during pregnancy and how to make decisions which can strengthen the couple's relationship [42]. Safe care, is always closely linked to health education and the SDG, which means safe pregnancy through regular visits to health facilities [3] and focus will be to reduce maternal and child mortality [43]. There is a need of interventions with capacity building in modern obstetrics, gynaecology and supportive policies and health institutions [44]. To teach students about skills and attitudes was inspiring to the SBAs. Refresher courses to strengthen the profession were appreciated and considered as a valued gesture from the operational manager. A persistent barrier to improving midwifery training includes the lack of investment in competent faculty in education [26]. Midwifery is associated with more efficient use of resources and improved outcomes when provided by midwives who are educated, trained and licensed midwives [45]. The SBA course contains details and techniques from manuals learned by heart. In a longer perspective, education for SBAs needs to include problem solving, leadership, professional autonomy and become recognised and appreciated by all medical educated professions. The SBAs work in most

areas of midwifery striving to decrease MMR. She worked in midwifery management, but without an academic degree as midwives. There are ongoing issues between policy makers and midwifery educational associations in Nepal about education to train professional midwives to meet the global standards of ICM [46]. Education is valuable for midwifery, and Nepal develops opportunities to reduce child mortality and improve maternal health. As an example of this the first cohort of the new midwifery programme will graduate during 2019 [20]. Advocates who want Nepal to strengthen the midwife profession require collaboration between the actors at different levels in society. The barriers are diverse political interests and priorities, the nurse's rival interests and societal views, divergent academic views on midwifery as a profession and insufficient communication. These matters are an on-going, challenging process in Nepal [47]. It is important to inform the society about the role and responsibility of an autonomous midwifery profession. However, courses when preparing midwifery students of evidence-based practice [48], implementations of programs [49] and development of assessment tools for affirming quality midwifery education have increased in other countries [36] and are recommended.

Limitations

When examining qualitative data, four concepts should be considered: *applicability, security, concordance* and *accuracy* [50]. *Applicability* means that the method was appropriate and the selection of participants and data collection adequate for identifying and studying the phenomenon 'the Nepalese SBAs' perceptions of their professional role. Phenomenography was found to be a suitable choice to describe the participants' qualitatively different conceptions about their professional role as SBAs, which was shown in the SBAs' quotations. As no previous research that had focused on their professional role, interviews were chosen to be preferred method for data collection. This was seen to

be the most beneficial way in which to obtain new knowledge and understanding of the phenomenon. In this study, the participants comprised only female SBAs, which could be considered a limitation. However, male SBAs are rare.

Security refers to how the data is received and how well it captures the participants' conceptions. The first author had no relationship with the participants and performed all the interviews in a similar way, which strengthened security. Before starting the interview, the participants received information about the study and how data would be handled. They received information about maintaining confidentiality and voluntarily participation. It is hard to know whether the Nepalese culture and the operational managers influenced the selection of the participants. However, the willingness to participate was high, although it is common for the operational managers to decide more than to ask about participation.

Concordance relates to how data was interpreted and described. During the analysis phase, all authors discussed the data in order to reach consensus about the result. The conceptions and descriptions categories were scrutinised, and separated from each other as far as possible.

Accuracy is about the authors' awareness and reflections during the research process. The first author's pre-conceptions as a registered midwife may have had an impact on the result, but this has been considered through the other authors' participation in the analysis process. To strengthen study accuracy, quotes were included in the results to enable readers to be co-examiners in gaining insight into the analysis of the participants'´ conceptions.

The data was collected in 2012 and this can be a limitation. Scientific papers on SBAs and their working conditions published after 2012 have been examined, and are in accordance the results of the present study [14; 46].

Conclusion and implications

The outcome of the study was to identify the SBAs' three roles; the role as provider, as counsellor and as educator, which they shifted between depending in varying situations. The SBAs perceived vulnerability in their work situation, especially when preventing complications and maternal death in rural areas. Lack of proper equipment and access to other medical professionals possible jeopardised patient safety. They also had to relate to the families' decisions, which could be culturally informed and complex and thus create an ethical dilemma. Knowledge and experiences were prerequisite qualities for the professional role of SBAs. Safety was closely linked to health education. The SBAs were problem solvers and made decisions on their own and in collaboration with colleagues.

A main issue for the professional role of SBAs are education at university level, the role and responsibility of an autonomous midwifery profession. There is a need of interventions with capacity building in modern obstetrics, gynaecology and supportive policies and health institutions. A change in the status of SBAs will affect every group of health professionals in Nepal, thus knowledge develops individuals and society.

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