The persistence and challenges of homebirths: perspectives of traditional birth attendants in urban Kenya

Chimaraoke Izugbara,* Alex Ezeh and Jean-Christophe Fotso

Through an analysis of focus group discussion data, we examine Kenyan traditional birth attendants’ (TBAs) accounts of the persistence of homebirths and the key challenges they present. TBAs associated the continued demand for homebirths with the wide-ranging character and quality of their services. They did not consider their lack of formal training on matters of pregnancy and birthing to be a particular challenge to their work. Rather, they identified the non-cooperative and disrespectful attitudes of their counterparts in hospital settings as the most important issue. Further efforts are needed to make TBAs realize how much better their services could become if they adopted more modern ways of assisting in deliveries, unlearnt their belief in the superiority of their particular type of practice, and understood how their lack of formal training is a key issue.

Keywords TBAs, Kenya, homebirths, persistence, challenges

KEY MESSAGES

- The TBAs identified the non-cooperative and disrespectful attitudes of providers in hospital settings as the most important issue affecting their work, and not their lack of formal training.
- They attributed the continued demand for their services to the high quality and wide-ranging nature of these services, and to their sensitivity to their clientele’s needs, which contrasts with the abusive treatment many women receive in hospital settings.
- There is an urgent need to make TBAs realize how much better their services would be if they adopted more modern practices. Their tendency to see themselves as providers of essential services can be built on here to ensure that they learn new methods and principles.

Introduction

Decades of modernization and the growing availability of medical technology notwithstanding, homebirths remain common in the developing world (De Vaate et al. 2002; Izugbara and Ukwayi 2003; Sibley et al. 2004; Izugbara and Ukwayi 2004; Izugbara and Brown 2006; Izugbara and Ukwayi 2007). Currently, about 53 million women in the South give birth at home annually, assisted mainly by traditional birth attendants (TBAs), most of whom do not possess the requisite skills to recognize, manage and prevent pregnancy-related complications (WHO 1997; Sibley et al. 2004). Surprisingly however, questions about homebirth, its persistence and the challenges of providing it have continued to be answered largely without inputs from and recourse to TBAs themselves. Information elicited from women seeking homebirths, and in some instances, the common-sense observations and assumptions of health system researchers and policy makers, remain the key sources of much of what is currently known about homebirths. In the bulk of the available studies, the social organization of homebirths, the socio-physical closeness of TBAs to their clientele, their acceptability and availability, as well as the sensitivity of their services to the cultural, economic and personal needs of the families, households and communities, are used to explain women’s continued quest for homebirths (Leedam 1982; Kamal 1992; UNFPA 1997; Kamal 1998). The literature is also replete with
claims that it is TBAs’ lack of scientific knowledge about pregnancy and related matters that poses the most critical challenge to their work (Kamal 1998). Given that available explanations regarding the persistence and challenges of homebirths continue to draw attention to the behaviour and conduct of TBAs themselves, their views on these issues deserve urgent hearing.

The present paper draws on qualitative data collected from TBAs in two slums in Nairobi, Kenya, in the search for their accounts of the persistence of homebirths and their constructions of the key challenges in their particular type of work. Our study is important in the context of current efforts to address poor maternal and child health outcomes in Africa. It could enrich current knowledge of issues surrounding maternal health in developing countries and deepen understanding of women and health in the transition towards global health sustainability. In this paper, we demonstrate that TBAs see the continued lure of their services as springing from the richness of the services they provide, as well as their ability to effectively mediate between what women want and what formal obstetric care service providers offer. We also show that TBAs do not consider their lack of formal training in pregnancy and birthing-related matters to be problematic. Rather, they see themselves as proficient providers who sometimes perform work of higher quality than their hospital-based counterparts. These findings are key and have important implications for maternal and child health care delivery in Kenya. In particular, they raise the need for an urgent rethink of current strategies for involving and mainstreaming TBAs in health care delivery in the global south.

The context

Kenya is a poor, multi-ethnic country in east Africa. It has a population of about 34 million. Vast disparities exist in health indicators and health services between provinces and between districts (Population Council 1998; Family Planning Service Expansion and Technical Support 2000). As in most of Africa, health care in Kenya is pluralistic. The context of health-seeking in the country therefore reflects a great diversity. Western biomedicine, faith healing, patent medicine shops and traditional medicine co-exist, and care-seekers choose among Western biomedicine, faith healing, patent medicine shops and seeking in the country therefore reflects a great diversity.

In this paper, we demonstrate that TBAs see the continued lure of their services as springing from the richness of the services they provide, as well as their ability to effectively mediate between what women want and what formal obstetric care service providers offer. We also show that TBAs do not consider their lack of formal training in pregnancy and birthing-related matters to be problematic. Rather, they see themselves as proficient providers who sometimes perform work of higher quality than their hospital-based counterparts. These findings are key and have important implications for maternal and child health care delivery in Kenya. In particular, they raise the need for an urgent rethink of current strategies for involving and mainstreaming TBAs in health care delivery in the global south.

Figure 1 A maternal health facility in Viwandani (APHRC 2005)
of formal maternal health care services, which occurred in Kenya in the 1980s and early 1990s have since undergone dramatic reversals following massive declines in the capacity of the Kenyan public health sector to provide maternal health services (Ndhlouv 1998; Population Council 1998; and Family Planning Service Expansion and Technical Support 2000).

The lack of staff training is another key area of concern. For example, only 15% of all Kenyan health workers providing maternal health services have received any type of in-service training in treating delivery-related complications. Research shows that antenatal, child delivery, postnatal and other child and obstetric care services provided in public health facilities are very substandard. Providers of these services are not only frequently unfriendly to women but also regularly fail to answer their questions, ask them for important routine information, and counsel them during antenatal care consultations. Provider harassment and mistreatment of women in public health facilities in Kenya is also reportedly rife (NCAPD and ORC Macro 2006).

As noted earlier, nearly 60% of pregnant women in Kenya give birth at home assisted by TBAs, and there is little evidence that this situation will improve soon. The situation is made particularly challenging by the fact that most of these TBAs have no formal training in child delivery. Lacking the capacity to recognize danger signs during pregnancy and in the periods surrounding it, these TBAs are often helpless when potentially fatal problems arise during child birth (Ministry of Health 2001). Also, Kenyan TBAs with formal training have been accused of frequently sliding back into their old ways of managing birth, often with disastrous consequences for the women who use their services (Kamal 1998). These issues notwithstanding, homebirths remain common in Kenya.

Research on the persistence of homebirths in Kenya, and in other southern societies, has seldom sought the opinions of TBAs. The bulk of what currently circulates as scientific information on the persistence of homebirths in Kenya is based largely on work among women seeking homebirths and developing memos on themes arising from the data as reflected in responses, ideas and words used by the TBAs. This process continued until all ideas were absorbed into

**Methodology**

This paper is based on a secondary analysis of qualitative data collected from TBAs in two slums in Kenya as part of a larger three-country study conducted in 2006. The parent study took place in Kassena-Nankana district, northern Ghana, Uttar Pradesh State, India, and Nairobi, Kenya, and sought to clarify the issues surrounding emergency obstetric care utilization in resource-poor contexts. In Kenya, as in the other two sites, both quantitative and qualitative data were gathered. Data were collected from several groups, including men, community leaders, young and adult fathers and mothers, and community-based health care providers, including TBAs. The Kenyan study took place in two slum sites in Nairobi where the African Population and Health Research Center (APHRC) operates a demographic surveillance system, the Nairobi Urban Health and Demographic Surveillance System (NUHDSS), with about 60,000 registered inhabitants.

Although a number of publications using quantitative data from the parent study have emerged (APHRC 2006; Fotso et al. 2008a,b), the qualitative data generated in this study have remained largely uninvestigated. Yet qualitative data on care giving and care seeking offer a unique and necessarily critical insight into matters of health and wellbeing, and could be instructive about the situation and context of health care delivery in a community (Yoder 1997; Obermeyer 1999; Kaddour et al. 2005; Izugbara 2006). Also, the importance of work with TBAs, particularly in the field of maternal and child health, has been widely noted (Izugbara and Ukwayi 2003; Izugbara and Ukwayi 2004; Izugbara and Brown 2006). In this study, we rely on focus group discussion (FGD) data gathered from 23 TBAs in two urban slum settings in Nairobi: Viwandani and Korogocho (see Box 1).

TBAs were identified and recruited with the aid of key informants, including women and TBAs in the two study communities. The two FGDs (one in each site) were conducted using a focus group interviewing schedule, administered in Swahili (Kenya’s national language) by trained female field-workers with high-level experience in conducting qualitative interviews. All the discussions were audio-recorded and later transcribed into English. The FGDs took place in private settings (a community school classroom and a civic hall), ensuring that the TBAs spoke freely. Among other things, the FGDs sought the TBAs’ knowledge of the signs of pregnancy, labour and obstetric complications, their views on why women continue to seek homebirth services, and on the key challenges in their work with women.

Data analysis for this paper involved thematic content examination of the two FGD transcripts, using in vivo coding. This involved reading transcribed texts many times over and developing memos on themes arising from the data as reflected in responses, ideas and words used by the TBAs. This process continued until all ideas were absorbed into

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**Box 1 The study sites**

Viwandani, about 7 km southeast of Nairobi’s city centre, is a settlement on a long and narrow stretch of reserve land owned by Nairobi City Council. Bordered by the industrial area and the Nairobi River, Viwandani covers about 0.52 km² and has a population density estimated at about 52,583 inhabitants per km². Korogocho covers a smaller area than Viwandani (0.45 km²) and has a higher population density (63,318 inhabitants per km²). Korogocho, which is located about 12 km east of the city centre, developed in the middle of the last century on land originally owned by one individual, a man called Baba Dogo, and on reserve land belonging to Nairobi City Council. The two settlements have high levels of unemployment, poverty and crime, poor sanitation and generally poorer health indicators compared with Nairobi as a whole. Korogocho is the poorer of the two settlements (APHRC 2006).
themes (Waskul et al. 2007). The themes and the connections between them were subsequently elaborated in order to identify cross-cutting ideas, issues and scripts. The categories that emerged were then contrasted with one another to guarantee the mutual exclusivity and specificity of their properties (Izugbara et al. 2005). In many instances, verbatim quotations are used to illustrate participants’ responses on relevant issues and themes. The data have been anonymized by the use of pseudonyms in the paper.

The present study has a number of limitations. First, it is a secondary data analysis, meaning that we worked within the existing data set. Second, it relies only on information gathered in two FGDs with a total of 23 TBAs, who are not representative of a national or local sample of Kenyan TBAs. Participants were only TBAs who agreed to participate in the study after being contacted by our key informants. It is therefore impossible to know how they differ from those who did not participate. In-depth individual interviews were not conducted with the respondents. It is possible that such interviews with some or all of the TBAs in the study area would yield richer information than we currently have. Also, it would have been nice to compare perspectives of women, TBAs and professional providers in the study area. While these limitations are important, they present fertile ground for future research.

**Results**

**The TBAs**

Twenty-three women, ranging in age from 28 to 70 and who self-identified as TBAs, were involved in this study. The majority of them were currently married with children. The average number of children was five. Judging by the available data, the TBAs are well patronized. Most of them had attended at least one birth and provided one or more maternal and child health services to at least one woman in the month preceding the study. Some had attended over five deliveries in this period. Wathee, a 45-year-old mother of nine children, had in the last month ‘‘helped deliver five babies and referred four women to hospital’’. Another TBA, who self-identified as a mother of six, reported attending four births and also providing several other services, including escorting a pregnant woman to obtain an HIV test. Hanau, a mother of two, confirmed assisting three pregnant women to deliver and personally accompanying two other women to a public hospital in Nairobi for specialized or emergency treatment within the same 1-month period.

Most of the participants had completed at least 6 years of formal schooling. One 70-year-old TBA also confirmed having undergone an adult education programme. Although the majority self-identified as Christians, the sample was ethnically varied, with most self-reporting as Kikuyu, Luo or Kamba. A substantial number of the TBAs had been providing homebirth services for a relatively long period of time. One respondent reported 10 years of experience as a TBA. She said, ‘‘I started this job in 1995 and I am happy with the work . . . serving the community. My wish is that . . . we could reach more people.’’ Some of the TBAs had worked in formal care settings, mainly as ward officers, cleaners and nursing assistants. One worked for several years in the hospital as an auxiliary nurse and reported first-hand knowledge of the severity of mistreatment and abuse suffered by women seeking obstetric services in hospital settings. Participants demonstrated positive attitudes toward and welcomed further training on birth assistantship and pregnancy management. Responding TBAs who had benefited from such training spoke glowingly of the many useful things they learnt as well as how such training made a difference in their work. TBAs also acknowledged that some of their practices could endanger the lives of mothers and their children. Such practices reportedly included the use of unsterilized and unhygienic tools during birthing, inserting bare fingers and certain herbs into a woman’s vagina, etc.

While only a few of the TBAs reported having undergone formal training in birth assistantship, several of them admitted to healthy relationships with public hospitals. They confirmed referring or personally taking some of their clients who needed special care to some public hospitals in the city and having them promptly attended to. One TBA noted that ‘‘we have a good relationship with Kariobangi City Council Hospital. In fact if you refer a woman to them with a letter, she is attended to without questions. Even sometimes we call them and they come to assist us.’’ The TBAs sometimes went out of their way to escort women to hospitals for many issues, including tests, consultations, diagnoses and even admission for pregnancy-related emergencies and conditions. They spoke frequently of providing antenatal and postnatal care, treating minor childhood ailments, and advising families and households on matters as wide-ranging as immunization, contraceptives, nutrition during pregnancy, and preparation for childbirth. One TBA noted that ‘‘sometimes we also get a letter from the chief to help women who have delivered at home to get birth certificates’’. Another spoke of taking ‘‘some mothers to hospital to have their babies given BCG and a clinic card’’.

The TBAs praised the government for according them official recognition in the country’s maternal health care delivery system. Regarding their relationship with the government, the mindset of most of the TBAs was captured thus:

> “The government did well to accept us (TBAs) since not all people are able to reach the hospital. They brought us tutors and we do appreciate. But the nurses abuse the patients and tell them that TBAs are useless and not well-learned or equipped. This does not augur well with us. Where were these nurses when government took this decision? Why didn’t they stop the decision? If only they could treat the patients well, more women would be encouraged to visit their facilities.”

The TBAs maintained regular contact among themselves, learning from and consulting each other on a number of important issues. Reports of seeking professional advice and help from fellow TBAs (especially during obstetric emergencies) dominated the narratives, as did disclosures of having learned one or more critical techniques from fellow TBAs. One respondent noted:

> “In one case, the baby got stuck . . . Instead of the baby moving downwards, it was moving upwards. I realized I couldn’t handle this alone so I sent for another TBA who came to assist. I climbed to the bed, held the mother upwards while my partner concentrated on the baby. I kept applying mouth to mouth respiration to her . . . we were . . .”
able to deliver the baby safely. The baby weighed four and a half kilograms. That was quite big for the woman.”

Overall, the TBAs considered themselves to be very useful and invaluable to society, particularly in the slums where households are poor and unable to afford basic medical care. They frequently depicted their work as an important service to humanity, noting that they filled a critical gap saving the lives of women and children and providing quality maternal care. In a graphic illustration of the importance of their work, one TBA shared a recent experience of hers:

“The other day at around 6 a.m., I met a lady giving birth on the roadside. It had rained and she was wet. The baby was in mud and there was no one to attend to the baby and mother. I just went taking things from people around to cover the baby. I picked stuff around and used them to cover the baby and shield it from the rain. I had not carried my tools for delivery. So I had to keep going to my pocket and this little boy who had stopped me to help the girl was very helpful. He was the one I kept sending to look for a razor blade to cut the umbilical cord . . . . So our work is very important in the community even if doctors and nurses look down upon us.”

Although several of the TBAs admitted to experiencing emergencies and near-misses in their practice, none reported assisting in a birth where a baby or mother died. TBAs who reported emergencies and near-misses also frequently confirmed taking immediate and often rewarding steps to help their clients reach hospital-based care. The narratives suggested that the insensitivity of hospital-based providers constituted the key barrier to the efforts of TBAs to help their clients reach and access emergency care. One TBA told us:

“In one case, the first twin came out, then the second one was stuck for good three hours. I had to get a vehicle to take her to Pumwani. On reaching within the vicinity, the car was stolen from us . . . . it was so bad and here I was with a small child and a weak mother who still had one baby inside her. At Pumwani, the nurses were only shouting at me and refused to listen to me. Eventually one woman came to my assistance . . . .”

Attractions of TBA services
Three key issues dominated the TBAs’ explanations regarding the persistence of homebirths: the wide-ranging nature of the TBAs’ services, the high quality of their services, and the responsiveness of their services to the socio-cultural and economic sensitivities of women. A consistent theme across the narratives surrounding the continued demand for TBA services was that they (TBAs) do more than provide delivery services; they reportedly provided services beyond the period of birthing. They spoke frequently of supporting and relating with women in the community long before, during and after their pregnancies. TBAs provided women with advice and information on contraceptives, as well as antenatal and postnatal care. They helped secure birth certificates for children, mediated between women and their husbands, and organized merry-go-round schemes that women relied on to deal with health emergencies. Some reported helping women bring their uncaring and erring husbands to the attention of the community chiefs, treating minor childhood ailments, advising families on a range of issues including nutrition during pregnancy and preparation for childbirth. The TBAs offered counselling services to unmarried women in the community, organized prayer sessions for pregnant women, took babies they had helped deliver for vaccination, arranged money and other materials for indigent women, and sometimes visited women at home to help with their household chores during pregnancy and the periods surrounding it.

One TBA reported that, “In addition to helping them during birthing, we do a lot for these women and invest a lot of time on them . . . . so they find it hard to do without us”. The implication of this, the TBAs admitted, was that very early on, the women in the community developed trust and confidence in them. A particularly interesting aspect of the narratives on the multiplicity of TBA services being a key attraction was that the study participants recognized the specific and general needs of the women they serve. This contributed to fostering a strong relationship between the TBAs and the women that sought their services:

“They also come to us when they are not even pregnant and we make sure to assist. We know each of them by name and know their problems. We also give them food to eat when they are unwell and advise them . . . . It means a lot . . . . when she gets pregnant she will come to you because of the existing relationship. Even when she can’t afford the money for a hospital card . . . (we) would rather provide it for her.”

Another frequently mentioned reason for the continued use of TBAs was that their services were not inferior to those provided in hospitals. Judging by their narratives, the TBAs believed that most hospital-based providers have little or no respect for them and also often dissuade women from seeking TBA services. However, they tended to dismiss these attempts as ineffectual, incapable of achieving much. Martha, a TBA with many years of experience, maintained that the vilification of TBA services by hospital-based providers and by the media in Kenya has been going on for years. As she noted, these efforts have yet to stop women from seeking homebirths. Martha maintained that the persistence of homebirths was an acknowledgment of the quality services which TBAs provide. Some of the narratives dwelt on how more maternal and child deaths occurred in hospitals than in traditional birthing homes, citing this as evidence that hospital-based providers were not superior to TBAs. Women reportedly continued to seek TBA services out of a realization that they were not inferior to hospital-based providers. Indeed, while the TBAs generally recognized the potential of the hospital setting, they frequently spoke of it as a place that women resort to when they anticipate emergencies and problematic births. One respondent remarked:

“What I can say is that in this community, women come to us because they trust the quality of service we provide. They only go to hospital when they know they will have those complications that we don’t handle.”

Another TBA said:

“As TBAs, we know what we are doing and the women also appreciate it and that’s why they continue to come to us.
Thanni, a 60-year-old TBA, echoed the above sentiment when she admitted that the majority of the women who seek hospital-based birthing do so out of fear of complications. She said that TBAs’ lack of skill in certain obstetric procedures does not make their practice inferior to hospital-based practice. Noting that TBAs also have many other skills which hospital-based providers reportedly lack, Thanni concluded that:

“women still use our services because we do our job very well. It is almost the same type of service they will get in the hospitals that we will give them. Many would love to come to us … but because of complications they go to the hospital.”

TBAs also explained the continued use of their service by women through reference to their high level of commitment to the wellbeing of women as well as to good practice. On this, the testimonial of the TBAs were very similar: they gave their best to their clientele, were fully committed to their wellbeing, and consistently maintained a high quality practice. These qualities contrasted with what they reported was the norm in the hospital setting, where women risked poor treatment in the hands of providers who showed neither compassion nor love.

The poor quality of practice found in hospital settings sometimes assumed very sinister dimensions, as reported by one TBA who claimed personal knowledge of hospitals and clinics where babies get stolen or exchanged and where mothers get treated with fake and expired medicines. Women’s awareness that such malpractices do not occur with TBAs reportedly encourages homebirths. Extortion and unkind behaviours by hospital-based providers were reported as other practices that encourage women to seek homebirths. TBAs maintained that in the quest for profit, most hospitals tended to subject women to unnecessary procedures (e.g. caesarean sections). One TBA noted that: “this is business … so that the hospital can get more money. Even situations that don’t warrant … the hospitals will make sure they invent something.” She continued: “Think of a mother of four. Why should she be stitched when she can have a normal delivery? All this is for the money.”

TBAs services reportedly contrasted with the inconsiderate and unaffordable services available in hospitals, a factor regularly mentioned as a key reason for the persistence of homebirth services, as one TBA remarked:

“The nurses even tell them [women] that they were not part of making the pregnancy. Statements like ‘you are not the only patient here for me to handle’, ‘push for yourself’, ‘that’s not my problem’, are used. They so abuse women and only listen to the heartbeat of the baby and don’t care about the mothers. But when they come to us, apart from being patient with them, listening to them, we will also give her a cup of tea after delivery to give her energy … I know what happens in the hospital, I used to work there.”

TBAs argued that not only was hospital-based obstetric care out of the economic reach of women, but also seeking it put women at risk of humiliation, neglect and abuse by providers. One respondent reported her personal experience:

“The doctors and nurses are normally very abusive towards women. When a woman goes through this abuse and maltreatment she gets discouraged to go for the next visit. I myself was told (in the hospital) that I was giving birth to children carelessly without planning so I decided to be having my children at home. My eldest daughter has been helping me.”

Another TBA also observed:

“They prefer us because at the clinics they are abused and ignored. But a woman will not expect me to come out of my house to go and render half services or ignore her because I value my work. Sometimes in the hospitals the doctors don’t have time to take care of them or have too many tasks. They also are too few in number thus making the women end up delivering on themselves … so they (women) feel … why should they waste their time going to the hospital.”

The sensitivity of TBAs to the needs of women was mentioned as a key reason for the continued use of their services. Responding TBAs argued that health-seekers had critical socio-psychological, economic and cultural needs, and that women’s continued preference for homebirths was not unrelated to the responsiveness of TBA services to these needs; for example:

“The issue is that TBAs treat women well. They relate with them. This is very important because it makes them come and even refer others to us. But if you are not very … understanding, patient and good to them … and you refer one to a fellow TBA, the woman will refuse because of her treatment or experience she had with the other one. These women are the ones who sell us to others. If your service is bad, then expect everyone to know about it. We also show them love, sometimes the hospitals don’t have time for them. We respect them and they respect us …”

TBAs suggested that hospital-based providers tend to disregard people’s cultural beliefs, maintaining that in hospitals, little or no attempt is made to find out and respect the cultural beliefs and preferences of patients. Wamboi, a TBA with 8 years’ experience, gave the following example, which resonated clearly in the narratives gathered from other TBAs:

“For instance, in the hospitals … things like placentas are carelessly disposed of. Whereas we give the women to carry with them unless, by herself, she says we could dispose of it. There are some communities that believe that if the placenta is thrown into a dump carelessly … the mother (and child) could be bewitched. Sometimes women are encouraged to come to us because we would respect their cultural beliefs.”

Another TBA stated that:

“Older women (may) not want to go and queue with younger mothers and even in the labour ward … Sometimes they feel embarrassed to be kept in the same labour ward with younger women. They are also sometimes insulted because of their age (by attendants in the hospital). To avoid these things, they come to us.”
The tendency of hospitals to stipulate harsh and unattainable requirements of poor women seeking care also emerged as part of the insensitivity that drew women to TBAs. Hospitals reportedly would ask poor pregnant women to meet certain rigorous dietary requirements, make cash deposits or provide blood, syringes, cotton wool and antiseptics as preconditions for admission. One TBA put it thus:

“The women also fear to go to hospital because they would be put on diet and they do not have enough money to buy the food. But we tell them to eat everything. But we tell them to eat well with the little money she has. For example, with Sh50 she can buy green vegetables and eat with ugali, drink soya, porridge, and eat banana. Even at the shop, we . . . tell the shopkeeper to mix all types of flour for her and this way she would have all the nutrients she needs . . . We tell them if you don’t have money for meat . . . beans would be very good substitute. And the women are comfortable with that.”

The TBAs identified poverty, the physical inaccessibility of formal care services, and the poor state of formal care services, as other factors responsible for the continued uptake of their services. For example, according to one TBA:

“The hospitals are crowded and are expensive. There is the transport issue and other small expenses that accrue along the way before you even reach the hospital. Then you will also need to leave some food in for the family.”

Women also reportedly sought TBA services due to a fear of undergoing some compulsory clinical tests, especially HIV tests, in the hospital. HIV was viewed as both rampant in the slums and affecting mainly women. The insistence of hospitals that women should undergo these tests, and the poor state of discriminatory treatment women are exposed to when they test positive (such as being quarantined to special maternity wards), reportedly also accounted for women’s concern over formal obstetric services.

The challenges

Throughout the study, TBAs regularly acknowledged that homebirths were fraught with challenges, which not only made it difficult for them to deliver their services effectively to their clientele, but also contributed to the negative images circulating about TBAs. However, it is important to note that the TBAs in the study do not see their lack of formal training on pregnancy and birthing as a key challenge to their work or the quality of services they provide. Rather, they frequently described themselves as proficient providers who only attend to matters in which they have expertise. One of them noted, “. . . we don’t carry out operations (surgeries) because it not our job . . . we know our job and we do it well.”

A common feature of the narratives elicited was that TBAs tended to refer women whom they suspect have complications during birthing to the hospitals. They often insisted that women using their services be registered in formal care facilities and also undergo an HIV test. They reported taking urgent steps to ensure that their clients who develop complications during homebirths reach a hospital in good time, which they generally maintained was an admission of respect for the limitations of their particular type of service.

TBAs suggested that most of the misconceptions circulating about them and their services were propagated by hospital-based providers who frequently accuse TBAs of providing services they know nothing about. Against this backdrop, responding TBAs framed the non-cooperative and disrespectful attitudes of their hospital-based counterparts as the most critical challenge to their work. They reported that they were often treated disrespectfully and disgracefully by nurses and doctors who many times have refused to cooperate with them even when lives were at stake. The TBAs cited instances when, while escorting their clients to the hospitals, they have been humiliated by nurses and doctors who call them names and refer to them as quacks. Disrespect and non-cooperation by formal providers were reportedly responsible for the demonization of TBAs in the eyes of the public and for putting their good work into disrepute. For instance, one TBA spoke of her personal experience of being insulted and caricatured while seeking a medical check-up in one of the hospitals where she was known as a TBA. In her words, “the nurse said she could not understand why I had come. She even asked me why I hadn’t sought the opinion of another TBA before coming to disturb them.” The disapproving attitudes of formal providers toward TBAs reportedly resulted in negative treatment against women. For example:

“They really look down on us because they feel they have been to schools to learn . . . sometimes they also treat our referral cases badly. For instance, if we refer a case to them they will tell the patient: ‘if you knew TBAs were better why are you here now? You women wait until you have problem then you rush to us for help. Just stay there and pray to God. I don’t care whether you die or not’, and many other revolting comments.”

The widespread poverty among their clientele was a major challenge to the work of TBAs. The majority of TBA clients are reportedly from poor households, are seldom able to eat well, maintain a good level of hygiene, pay for antenatal care, or even undertake hospital registration. Also owing to poverty, some are unable to adequately prepare for childbirth or cater for their babies. They are often unable to set money aside for emergencies. These factors reportedly often undermine the good work of the TBAs. Clients who come unprepared, do not eat well and are not healthy frequently experience complications for which TBAs get blamed. Dealing with a poor clientele reportedly frustrated the TBAs’ efforts to deliver a good service.

The weak national maternal health delivery system in Kenya was also reported as a challenge to the work of TBAs. Participants argued that the public hospitals are poorly staffed and lack critical medications. Women attending antenatal care in hospitals get neither adequate attention nor the drugs they require. They ultimately return to the TBAs untreated, sometimes resulting in fatalities during homebirths. As one TBA put it: “There are no medicines (in the hospitals) in the first place. Women are only given prescriptions to go and buy medicines. Or they will be given expired drugs. These women can hardly afford the medications . . . they just hope their ailments will go.” Often, as TBAs suggested, these ailments do not go, but remain to cause complications during delivery.
TBAs maintained that formal recognition by government notwithstanding, several ambiguities remain with respect to their role in the health care system. These policy ambiguities reportedly contributed to the disrespect which TBAs suffer in the hands of hospital-based providers and also to their lack of effective integration in the country’s health system. TBAs maintained that the weak national health delivery system was to blame for their inability to access regular training as well as some of the key equipment (such as weighing balances, thermometers, gloves etc) which they need to be effective in their work. Summing up this sentiment, Ma Adina noted:

“The government is also part of our problem. Government demoralizes us rather than train, equip and encourage us. We need to mix with the nurses so that we are able to work together for a good cause (of saving the lives of women). But we have not done so yet because things are not very clear. This is why currently the nurses feel that we are not doing a good job.”

Other challenges identified by the respondents were gender inequality and dishonesty among women. While the former reportedly prevented women from making decisions on pregnancy-related matters without consulting their husbands, even during emergencies, the latter encouraged women to conceal certain information about themselves from TBAs, such as their HIV status and other important medical information. It was also reported that, through greed, some women with little or poor knowledge of birth assistantship, and therefore unable to effectively manage the period of birthing, have joined the profession, resulting in ugly incidents that have tarnished the reputation of TBAs in society.

**Discussion and conclusion**

Although research on homebirths and their challenges has recently proliferated (WHO 1992; Sibley et al. 2004), the perspectives of TBAs (who assist in the majority of homebirths) remain unexamined. This study sought to add to the knowledge base by exploring the perspectives of Kenyan TBAs on the persistence of homebirths and the key challenges involved in providing them. The accounts of TBAs add significantly to what we know about homebirths and why they persist. They clarify issues regarding the centrality of the behaviours of TBAs and other providers to the persistence of homebirths. The study confirms previous work about the perceptions of TBAs and their claim to provide a high quality service, especially around ‘tender loving care’ in contrast to the treatment in hospitals, calling attention to the need to rethink current strategies for involving TBAs in maternal health care delivery.

The data gathered show that TBAs in the study were regularly utilized, with many of them attending as many as five births a month. TBAs also served the women in many other ways, including taking them to hospitals to get tested, registered and treated. They provided antenatal and postnatal care, treated minor childhood ailments, and advised families and households on issues as wide-ranging as immunization, contraceptives, nutrition during pregnancy, and preparation for childbirth. The TBAs considered themselves to be very useful in Kenya, and particularly in the slums where most households are poor and unable to afford quality formal care. They saw themselves as very essential to the delivery of quality maternal health care in the country. The tendency of TBAs to rate their work very highly, to talk of it very proudly and to see themselves as providers of essential services, as the unsung heroines of maternal health and wellbeing, has been noted in earlier studies (Camey et al. 1996; De Vaate et al. 2002; Mathole et al. 2005; Izugbara and Brown 2006). This is critical as it presents an entry point for sustainable work with TBAs.

The TBAs attributed the continued demand for their services primarily to the fact that they do more than provide child delivery services, as detailed above. One result of their diverse service provision, as many TBAs admitted, is that very early on, women in their communities develop trust and confidence in them, seeing them as the providers to consult when they need help. This finding is key for various reasons. First, the role played by the assortment of services that TBAs provide to women in the persistence of homebirths has yet to feature in the literature. But from the available narratives, it is obvious that the provision of these various services (some of which preceeded or followed child delivery) helped TBAs to become the health care providers of first resort among women for child birth.

Second, the confirmation by TBAs that they do more than provide child delivery services to women is also critical. Research on TBAs continues to present them as mere providers of birthing services, neglecting the other services for which they are also often sought. Among others, Leferber and Voorhoeve (1997), Walraven and Weeks (1999), and Izugbara and Ukwayi (2003, 2004) have noted that TBAs do more than deliver babies. They argue that TBAs provide key health and non-health services for their clients. TBAs in the present study provided help, advice and information on issues ranging from contraceptives to nutrition during pregnancy, from preparation for childbirth to antenatal and postnatal care. They secured birth certificates for children born at home, mediated marital relationships, operated emergency fund schemes for women, treated minor childhood ailments, organized prayers for pregnant women, and took babies for vaccination. They also visited pregnant and post-partum mothers at home, helping them with household chores.

Other factors mentioned by TBAs as responsible for the continued demand for their services included the non-inferiority of their services to hospital-based services, their high level of commitment to the wellbeing of women, and their sensitivity to women’s socio-economic and cultural preferences. Their services reportedly contrasted with what happened in the hospitals, where it was said that women suffer extortion and poor and inconsiderate treatment. TBAs in the study appear to be fully aware of the needs of the women they serve, and tended to aim their services to respond to the sensitivities of women and their families. TBAs’ views that the sensitivity of their services to women’s needs is responsible for the demand for homebirths are supported in the literature. Studies show that the major attractions of TBAs revolve around service characteristics such as affordability, accessibility and reliability (Walraven and Weeks 1999; Kamal 1998; Izugbara and Ukwayi 2003, 2004, 2007). In Kenya, as in most of Africa, formal health care services are not planned to recognize and respect
health-seekers’ needs and preferences (Ondimu 2000a,b; Agwanda 2006). A mismatch between the values, needs and sensitivities of health-seekers and providers thus occurs frequently in the Kenyan formal health sector and tends to hinder the use of formal maternal care services. Also, formal health care providers in Kenya are sometimes very unfriendly to and dismissive of women, especially poor women. They tend to ignore them and generally treat them very rudely. Poor patient–provider relationships and provider inattention to health-seekers’ concerns are major barriers to the uptake of formal care services in developing countries (NCAPD and ORC Macro 2006).

It is significant that TBAs in the present study did not consider their lack of formal training on matters of pregnancy and birthing as a key challenge to their work or to the quality of services they provide. Rather, they identified the non-cooperative and disrespectful attitudes of their counterparts in hospital settings, the weak national maternal health delivery system, and widespread poverty among their clientele as key challenges. Participants noted that despite being formally recognized by government, several ambiguities remain with respect to their role in the health care system. These policy ambiguities were blamed for many things, including the disrespect which TBAs suffer in the hands of hospital-based providers as well as their lack of effective integration into the country’s health system. Kamal (1998) is of the view that health policymakers, planners and implementers in developing countries have only grudgingly and half-heartedly accepted the real and potential usefulness of TBAs. In many contexts therefore, there is little concrete or long-term effort to integrate them formally.

The implications of these findings for formal work with TBAs in maternal health care delivery are complex. TBAs’ tendency to depict themselves as providers of essential services is key as it can be built on to ensure that TBAs learn sustainably and adapt well to new knowledge and principles – though this must be at a level which the TBAs can comprehend and apply effectively (de Vaate et al. 2002). Further, the various capacities under which TBAs admitted to serving the women suggest limitations in current TBAs training. Historically, the training available to TBAs in most of the South aims to equip them to recognize complications and emergencies and to ensure clean, safe delivery. Rarely does this training cover first aid measures for obstetric emergencies or all the areas of health in which they are involved, including family planning, environmental sanitation, immunization, postnatal care, etc.

Yet TBA training for an expanded role is neither a panacea nor a simple task. Indeed, the impact of TBA training on maternal outcomes is seriously contested. While some (such as Mangay-Maglacas and Pizurki 1981; Kamal 1998) believe that TBA training has the potential to save women’s lives, Berer (2003) and Tinker and Koblinsky (1994) suggest otherwise, arguing that in the absence of skilled back-up support, TBA training does not reduce women’s risk of dying during childbirth. The inability of training to improve a TBA’s ability to save women’s lives is, however, largely because TBAs simply do not have the skills to do more than assist at uncomplicated births in very basic ways (Berer 2003). Also, the training offered to TBAs is often too short to make any difference. Currently, the longest recorded TBA training period is 3 months and most of it deals with normal labour, recognizing expected and actual deviations from normal labour (Kamal 1998). But given that the existence of TBAs remains a reality and that they continue to deliver the overwhelming majority of babies in Kenya, the challenge is for policymakers to make the best use of them while working towards a replacement strategy (Kamal 1998). In this respect, we argue that TBAs still have a relevance that could be strengthened through extended training both in terms of duration and focus. Therefore, recognizing the various health and non-health roles that TBAs play and offering them extended and comprehensive training on those appears to the way forward. De Vaate et al. (2002) argue that an inventory of the roles, practices, services and beliefs of TBAs would be helpful for the development of appropriate training programmes. TBAs’ tendency to see their lack of formal training on matters of pregnancy and birthing as a non-issue, to view their service as superior (or at least not inferior) to hospital-based services, and to frame the non-cooperative and disrespectful attitudes of their counterparts in hospital settings as the main challenge in their work are also important findings. Although addressing the structural underpinnings of these beliefs and values may require socio-economic transformations beyond the scope of conventional public health campaigns or further research, there is an urgent need to make TBAs realize how much better and improved their service would be if they adopted more modern ways of assisting in deliveries, and permanently learnt their beliefs in the superiority of their practices; to make them understand that their lack of formal training is a key issue. And TBAs in the present study appeared willing to do just that. They expressed both a willingness to work with hospital-based providers to improve their practice as well as a readiness to undergo further training. Several studies have noted that as part of their continuing education and process of unlearning their practices, and as a mechanism for building their confidence and respect, TBAs could be allowed to conduct deliveries in health facilities (Kamal 1998; De Vaate et al. 2002; Sibley et al. 2004). However, such training must be devised so that it does not give TBAs the impression that their services are considered inferior or that, while hospital-based providers have a lot to teach them, they (TBAs) have nothing to teach hospital-based providers. Getting hospital-based providers to see the advantages in having skilled TBAs assist in maternal health care delivery in resource-poor contexts is as important as getting TBAs to realize that they would do better with regular training. Equally important is for communities to realize that a trained TBA would serve them better (De Vaate et al. 2002; Sibley et al. 2004).

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References


