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PERCEPTION ABOUT TRADITIONAL BIRTH ATTENDANTS BY MEN AND WOMEN OF REPRODUCTIVE AGE IN RURAL MIGORI COUNTY, KENYA

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ABSTRACT

Background: Skilled birth attendance, a proven way of reducing maternal and perinatal mortality has remained low in low resource settings. Traditional Birth Attendants (TBAs) have continued to be culturally and socially accepted in many societies despite their limitation in handling childbirth complications. The study objective was to assess the perception of traditional birth attendants (TBAs) by the men and women of reproductive age in rural Migori.

Methodology: This was a qualitative study carried out in four villages in Migori County, Nyanza region which involved married women of child bearing age and married men. Separate focus group discussions (FGDs) were done for men and women, where one FGD was conducted per group in each village. Content analysis was done after coding and categorizing data into thematic areas.

Results: The findings indicated varied perceptions of men and women about the TBAs. Themen appreciated the services of TBAs mainly because of financial reasons while women enjoyed their friendly attitude and welfare services. The community was well aware of the risks of delivering

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with a TBA, however, they still opted for their services for reasons such as availability, accessibility and their friendly attitude.
Conclusion: The men and women of reproductive had varied perceptions, both positive and negative about the traditional birth attendants. The TBAs still have a role to play in the community.

KEY WORDS: Traditional birth attendants, skilled birth attendance, Community perception, Home delivery, maternal mortality

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INTRODUCTION

There have been significant efforts put in place to encourage mothers to seek skilled birth attendance which, has been found to contribute to a reduction of maternal mortality. These efforts include health education on importance of skilled birth attendance and also upgrading health facilities to offer emergency obstetric care. In Kenya, the government started offering free maternal health services since 2013 as a way of encouraging utilization of skilled care at birth. Maternal mortality is a global public health challenge owing to the statistics indicating a lag in its improvement(WHO, 2010). Every year worldwide, over 500 000 women die of pregnancy and child birth - related complications(WHO, 2014). The rates of mortality are unacceptably high in the developing world especially in the sub-Saharan Africa(Alvarez, Gil, Hernández, & Gil, 2009; WHO, 2014, 2015b). In sub-Saharan Africa, the maternal mortality rate is the highest across the global at 500 per 100000 live births whereas regions like Asia record 220 per 100000 while Caribbean and Latin America is 80 per 100000 (WHO, 2015b). In Kenya, statistics indicate that the mortality rate is 362 per 100 000 live births(Kenya Demographic and Health Survey, 2014).

Most of the causes of maternal mortality are preventable especially through utilization of skilled care at birth(WHO, 2015a). There has been a challenge in utilization of skilled care in many developing countries since despite many women attending antenatal care in the hospital, few of them deliver with skilled attendance(Wang, Alva, Wang, & Fort, 2011). Most health facilities, both public and private offer maternal health services which include antenatal, labour and delivery and postnatal services. Unfortunately, most of the available government health facilities

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are the lower level facilities which do not offer maternal services(Ministry of Health, 2014). This renders the higher level facilities busy and the staff become overstretched due to client overload. A higher proportion of births is attended to by unskilled care in Kenya especially in the rural areas. According to KDHS 2008/09, only 44% of pregnant women received skilled birth attendance(KDHS, 2008-09) while the antenatal care (ANC) attendance was 92%. In 2014, skilled birth attendance increased to 62%while antenatal care attendance was 95% (Kenya Demographic and Health Survey, 2014). These statistics indicate that there are women who attend ANC whereas do not seek skilled care at birth. Despite the efforts made by the government such as offering free maternal health services to improve skilled birth attendance, a proportion of the population still rely on traditional birth attendants.

ATraditional Birth attendant (TBA) is “customary”, autonomous (of the health system), non-formally trained and community based providers of care during pregnancy, childbirth and the postpartum period(World Health Organization, 2004). TBAs either trained or not, are excluded from the category of skilled health workers. A skilled care attendant is one who is accredited and has been educated and formally trained in management of complicated and uncomplicated pregnancy and childbirth(World Health Organization, 2004). TBAs in most cases are community resource persons who attend to pregnant women especially in the rural areas where access to the health facility is a challenge and they have proved to be assets in offering assistance to pregnant women(Roro, Hassen, Lemma, Gebreyesus, & Afework, 2014). Traditional birth attendants have been in existence and have been attending deliveries in many societies. They play a cultural and social role, however the government is phasing them out in anticipation to increase skilled birth attendance(Byrne & Morgan, 2011).Despite their vast experience in assisting deliveries, they are faced with the difficultyof managing obstetric complications leading to an increased the risk of maternal and perinatal mortalities(Wilson et al., 2011).

Traditional birth attendants have been there in the communities however they are not recognized in the health sector despite having a proportion of women seeking their services for delivery.Following their existence in the communities, they could be used to promote maternal and essential newborn health(Falle et al., 2009). Establishing the perception of the community about the TBAs will enable launching of strategies that will enable to address the low utilization of skilled care at birth. When women utilize skilled care, it makes it possible to manage complications of pregnancy and childbirth which may not be handled by the TBAs owing to lack of knowledge and equipment. Improving maternal health will contribute to the health of the family and the community at large. This will also translate to achievement of Sustainable Development Goal (SDG)3 which its goal is to reduce maternal mortality to 70 per 100000 live births globally by the year 2030.

In Migori County, the number of women who deliver with skilled attendance is 53.4% and those who attend at least four antenatal visits are 54.6% (Kenya Demographic and Health Survey,

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2014; Ministry of health, 2016). Of those who utilized unskilled birth attendance, 28.6% were delivered by TBAs (Kenya Demographic and Health Survey, 2014). This indicates that the TBAs have a place in the community regarding maternal health.Migori County has a total of 126 public health facilities with a nurse – patient ratio of 32 per 100000 people, doctor – patient ratio of 4 per 100000 people and clinical officer – patient ratio of 19 per 100000 people(M.O.H, 2015). This is way below the government nurse – patient ratio of 55 per 100000 people, doctor patient ratio of 10 per 100000 and clinical officer – patient ratio of 21 per 100000 people (M.O.H, 2015).
This study aimed todescribe the perception about the traditional birth attendants by men and women of reproductive age in rural Migori County, Nyanza region of Kenya.

MATERIALS AND METHODS

Study design

This was a qualitative study where Focus Group Discussions (FGDs) were used to collect data among men and women of reproductive age.

Study area

The study was carried out in Migori County, Nyanza region located in the southwestern part of Kenya.The Countycomprises 5 constituencies (Rongo, Migori, Uriri, Nyatike and Kuria). It has a population of 1,071,535and an area of 2,005 km²(M.O.H, 2015). The poverty rate in the County is at 42.5%(CENSUS, 2010).

Selection of villages

Multistage sampling was employed to select the County of study. With the guidance of the Health Management Teams in the County, two administrative divisions with poor maternal and infant health indicators were selected for the study. In the two divisions namely Suna West and Suna East there are a total of eight villages. The names of the villages in the divisions were written on pieces of paper which were then folded and placed in a container and shaken so that random picking of four villages would be done. A blindfolded community health volunteer then picked out randomly four folded pieces of paper bearing the village names from the container. The villages thus randomly selected and where the study was carried out were: Ogwedhi, Ondong, Godkwer and Nyamaraga.

Selection of the participants

The study was carried out among men and women of reproductive agein the selected villages.The criteria for participation was that they should have resided in the community for a period exceeding one year, they should have had information about TBAs and the women should have been within the reproductive age (15-49 years). Health care providers and traditional birth attendants were excluded from the study.

Conducting FGDs

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FGDs were conducted in the afternoons after people had retired from their day activities. One of the researchers who is experienced in carrying out FGDs led the discussion while another researcher took notes during the discussion. FGD guides were used to direct on the focus discussion areas. The FGD proceedings were audio-recordedafter seeking the participants' permission.Eight FGDs were organized, two in each village where there was one women and one men FGD. In addition, the single parents were excluded since the study aimed to establish the role of men and their perception of TBAs. Each FGD consisted between 8 – 12 participants. A total of 80 respondentsparticipated in the FGDs where data was recorded.The FGDs were held in an identified place in the village shopping centre. A market day was chosen for the interview as most people would be in the shopping centre. The men were interviewed on a different day from the women. During the interview, a question guide was used by the researcher who led the discussion. Each participant was allocated a random number for anonymity purposes.

Insert table 2 here

Data analysis

The recorded data was transcribed, with responses being grouped according to emerging themes.Reliability was ensured by checking the transcribed data against the verbatim. Data was analyzed through content analysis where coding was done to categorize responses then interpretive analysis of the findings through reading and re-reading of the responses.

Ethical considerations

Ethical approval was sought from Kenyatta University Ethics Review Committee (KUERC) and a permit from the National Council of Science, Technology and Innovation (NACOSTI).Care was taken to ensure that respondents' confidentiality was maintained throughout the study.

Study limitations

It is important to acknowledge that this study was faced with limitations. Data was collected in four villages with a small sample size in each village representingmen and women of reproductive age. This was self-reported data were the participants gave information based on their experiences. There was the risk of attribution or exaggeration of information. This was delimited by asking similar questions to validate the information received. This study did not interview the TBAs to get their perception or comparative analysis.

FINDINGS

A total of 38 men and 42 women participated in the study. From the findings, the emerging themes of the study were: availability of TBAs, accessibility, perceived skills of TBAs and the

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quality of services provided by the TBAs.The verbatim quotes werelabeled according to the group, whether men or women FGD.

Socio – Demographic Data

The men who participated in the FGDs were aged between 18 – 67 years old while the women were aged between 16 – 43 years of age. On education level, most of the men 25(65.8%) had attained post-primary education while most of the women 23 (60.5%) had attained primary level of education. Most of the men were self-employed 27(64.3%) while others were students 3(7.1%). Most of the women were self-employed 23(60.5%), 2(3.6%) where still studying while 12(31.6%) were unemployed. Table 2 illustrates the socio-demographic characteristics of the study population.

Availability of TBAs

The community cited a number of reasons for seeking TBA services. One reason why the TBAs were more preferredwas because they were more readily available since they lived within the community unlike health facilities which are far. The TBAs are members of the community and they could be reached at anytime.

"These women live with us. I can go to her house at anytime".

"I don't need to have money to see the TBA because she is my friend".

Distance to the health facility

The participants cited that the health facilities were far away and they experienced transport challenges in terms of cost, lack of transport means and poor road network. The commonest means of transport available for the respondents was *bodaboda* (motor cycle transport). Unfortunately, these motorcycles do not have a comfortable carrier for a pregnant woman.

"The health facility is far" (Women FGD).

"There are transport challenges due to poor roads and no vehicles" (Men FGD).

"It is difficult for a pregnant woman in labour to sit on a bodaboda" (Women FGD).

Partner support

Lack of support from the partner was cited as a reason that was known to facilitate home delivery. From the study, women valued support from their partners during pregnancy and childbirth. They indicated that they needed a birth companion and most of the time in the health facility they would be alone. They chose to deliver with the assistance of TBAs since they offered the role of companionship to the woman.

"Those women with irresponsible husbands or those working away from home miss help of their husbands escort" (Women FGD).

Some women reported that they could forget their due dates while for others, labour began suddenly thus they did not reach the health facility for delivery. Others lacked the knowledge on the importance of hospital delivery.

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"Abrupt labour and also cases of women forgetting their due dates makes the women to deliver at home" (Women FGD).

"Some women lack education on the importance of hospital delivery" (Women FGD).

Preference for hospital delivery

From the women FGD, the participantspreferred hospital delivery since complications could be detected as evidenced from their experiences.

"In hospital, complications can be detected and dealt with for both the mother and the baby" (FGD, women).

"It is safe, and my first pregnancy was twin, I was assisted and delivered first twin well and the second twin was due to caesarean section. If I delivered at home, I could have died" (FGD, women).

Positive perception of the community about Traditional Birth Attendants

There were a number of reasons why the community perceived the TBAs positively. These included the negative staff attitude in the health facilities, cost of delivery at the health facility in comparison with the TBAsand the services offered by the TBAs in comparison to hospital delivery during and after delivery. Negative staff attitude and past negative experiences in the health facilities was contributory factors to women opting to deliver with the assistance of TBAs.

"Nurses are very rude. I was abused and not encouraged during my last delivery" (FGD women).

"I went to deliver and they demanded for money for Jik and everything. I was in pain and they left me alone until I delivered by myself" (FGD women).

"I went to deliver, the nurses were pinching and beating me. I was traumatized and I swore never to go back. The third born I went to the TBA. The fourth born, I decided to go to the district hospital and the treatment was the same" (FGD women).

The participants said that the mode of payment of the TBAs would be done in kind and in installments as compared to the hospital payment. The participants said that it was cheap to deliver with a TBA since they would accept any form of payment that their client had.

"Men prefer the TBA because they cost less than Ksh 500.00 or even a chicken" (FGD Men)

"The TBAs are easy to reach and are cheap because you can pay them with a chick or hen" (FGD Men).

Negative perception of the community about Traditional Birth Attendants

Some women cited some disadvantages of delivering with the TBAs which included some traditional practices and lack of infection prevention measures which exposed them to infection and unavailability of certain services such as weighing of the baby.

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"The baby is not weighed" (FGD women).

"The mother is exposed to all dangers. The TBAs use the sugar cane covers or their nails as razor blade for cutting the cord" (FGD women).

"They don't have gloves and use paper bags. I don't like that because of infection" (FGD women).

Quality of care provided by TBAs

The women valued the quality of care provided by TBAs and they appreciated delivering with them because of the services they(TBAs) offered them as compared to the hospital where sometimes welfare services such as food or assisted bath are lacking. They enjoyed the individualized care provided to them in the TBAs setting since they would only be few at a time. The women also believed that the TBAs offered some herbal medication that could assist in quickening the labour process. The services offered by the TBAs were friendly as said by the participants.

"Immediate good food after delivery, ready made" (FGD women).

"There is the belief that TBAs are fast in deliveries and they give the women herbs that assist them" (FGD men).

"Most of the time, you are alone and the TBA will be there without leaving you. She will console you when you are in a lot of pain and encourage you". (FGD women).

From the study, women feared attending the health facilities because of the services offered in the health facilities such as HIV testing and caesarean section. They did not want to have the services done on them thus opted for TBA delivery.

"Some women do not deliver in hospital because they believe they will be tested for HIV and they will be known to be positive" (FGD women).

"There is no operation involved in TBA delivery" (FGD women).

Comparison of men and women's perception of TBAs

From the findings, the men perceived TBAs as being cheap since they preferred any mode of payment, however women cited the risks involved in TBA assisted deliveries compared to skilled birth attendance. This was cited because of the materials TBAs would use during the delivery procedure. Men did not think about infection however, their concern was the cost of delivery. The women were worried of the possible risks such as infectionthat could occur while being assisted by TBAs.

DISCUSSION

This study was designed to assess the perception of the rural community about the TBAs. The study findingsindicated how the community perceives the traditional birth attendants, both in support of their role in assisting the women to give birth and otherwise. There are negative

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perceptions owing to their lack of knowledge in managing complications and the materials and equipment they use during childbirth. It has been proven that skilled birth attendance is one measure in reducing maternal and neonatal mortality and also stillbirths (Singh, Brodish, & Suchindran, 2014; WORLD HEALTH ORGANIZATION, 2016; Yakoob et al., 2011). A review of articles on how to increase skilled attendance at birth found out that there were a number of factors which needed to be addressed including distance to the health facility, transport availability and family choices and supportand use of TBAs as birth companions (Tomedi, Tucker, & Mwanthi, 2013; Vieira et al., 2012).

Availability of TBAs

The challenges cited in this study limiting hospital delivery included distance to the health facility which would imply clients incur added transport cost, lack of transport means and poor road network thus contributing to home delivery. Distance to the health facility was established by a study in Makueni County, Kenya which found out that it was a factor contributing to unskilled delivery (Gitimu et al., 2015). In low resource settings, road infrastructure may be a challenge which could contribute to home delivery since the weather roads may be impassable especially during rainy seasons thus making it difficult to travel to hospital. The presence of TBAs in the community makes them more accessible since the woman does not have to travel far. Similar findings were found in studies toassess factors contributing to home delivery in Tanzania (Simfukwe, 2011) and also in Indonesia (Titaley, Hunter, Dibley, & Heywood, 2010).

Accessibility of TBAs

Comparing the men and women responses in this study regarding place of delivery, there was a difference in their opinions sincemost women mostly preferred skilled birth attendance while some of the men opted for the TBA mainly because of financial reasons. This may be argued that men may not understand the risks involved compared to women who actually experience them. Another reason why women preferred skilled birth attendance was the risks of infections and complications among the TBAs. Similar findings were established in a Tanzanian study which established that presence of drugs, medical equipment and trained personnel was a reason for choice of health facility delivery(Yanagisawa et al., 2013).Lack of partner's support for hospital delivery could also be attributed to the cultural values and beliefs and myths surrounding childbirth. Many African cultures believe that delivery is a matteronly concerning women thus male support may be limited. Similar findings were found in studies in Ethiopia where there was cultural significance of deliveries conducted at home by TBAs(Titaley et al., 2010; Vieira et al., 2012).In some cultures, there are certain rituals that follow delivery whereby the home provides a good environment. Another study in Pakistan found out that family tradition and the socioeconomic status played a role in contributing to home deliveries(Titaley et al., 2010).Tradition

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From the study, some of the women reported that they delivered at home because the labour began suddenly while for some, they said they had forgotten their expected date of delivery. For some, they lacked knowledge on the importance of hospital delivery. This could be attributed to low level of education which may make the women ignorant. The study findings are similar to findings of a study carried out in Ethiopia to find out reasons for home delivery(Shiferaw, Spigt, Godefrooij, Melkamu, & Tekie, 2013). These findings raise some questions: Do women receive health education about labour and delivery? How is the information delivered during the antenatal visits? Do they understand what is written in their antenatal care (ANC) booklets? Does anyone care to interpret what is written? A study should be designed to address these concerns.

Perception of the Community on Traditional Birth Attendants

There were various reasons why the community preferred TBAs to assist in the deliveries. TBAs are members of the community who can be relied on according to the study findings such that they can avail the care required to pregnant women especially at night. The findings indicated that TBAs were chosen because of their availability and accessibility. This could be attributed to the fact that TBAs are available and could easily be accessed even at night. Similar findings have been found in other studies(Asuquo, Etuk, & Duke, 2000a; Dorwie & Pacquiao, 2014).Other studies have cited the need to train the TBAs to enhance their effectiveness in delivery of care(Ebuehi & Akintujoye, 2012; Imogie, Agwubike, & Aluko, 2002).

Another reason why they were chosen was the cost of delivery. The respondents said that the TBAs were cheap compared to a health facility delivery. This could be because payments of TBAs would be paid in kind such as a chicken or in installments. In addition, their services are much cheaper compared to health facility charges. Similar findings have been found by various studies(Shiferaw et al., 2013; Titaley et al., 2010). At the time the study was done, the government had not yet rolled out free maternal health services in the country therefore hospital bills were a challenging issue among the community members.This could explain the reason why men in the FGDs preferred the TBA services since they are mainly the bread winners in most households and hospital delivery makes them to incur costs which required prompt payments unlike the TBAs who could be paid in kind. This indicates that there are services offered by the TBAs which are liked by the community as compared to the health facility.

The services provided in the health facility or the TBA offer attraction of the clients. Study findings indicated that TBAs offered better services like hot water and good food after delivery as compared to what happens in the health facilities. This could be attributed to the fact that the TBAs are likely to be having fewer patients at a time, making it easy to provide these services as compared to the health facilities where sometimes there could be largepatient numbers and understaffing leading to unavailability of such services or the services may not be timely offered.

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The participants cited that the TBAs would be able to quicken the labour process through the use of some herbal drugs which a woman is given during labour. A study investigating use of medicinal plants by TBAs during pregnancy found out that their knowledge of the herbs is important although women should be encouraged to utilize skilled birth attendance(Kaingu, Oduma, & Kanui, 2011). Studies have found out that herbal medicine have been used in many countries in developing world, however the suitability to certain conditions should be evaluated(Imogie et al., 2002; Kaingu et al., 2011; Rajesh, Moyna, & Goutam, 2013). More investigation should be done to establish the relationship of these herbal medicine and shortening the process of labour.

The health facility is a new environment to most clients, thus the staff help to create rapport by showing a positive attitude to them therefore enable them feel accommodated. Negative staff attitude was cited as one of the reasons why women preferred to be assisted by TBAs during their deliveries. Similar findings have also been found in other studies(Asuquo, Etuk, & Duke, 2000b; Dorwie & Pacquiao, 2014). Negative staff attitude could arise from poor staffing thus making the staff to overwork as a result affecting the quality of services offered in the facility. TBAs have been known to provide compassionate care as indicated from the study findings which are in agreement with other studies(Ebuehi & Akintujoye, 2012).The TBAs do not handle many clients at any one time making it easier for them to be more caring as compared to health care providers who may already be strained due to the huge patient volumes. Health care facility barriers such as negative staff attitude hinder access to health care thus contributing to high maternal and perinatal mortality rates(Dorwie & Pacquiao, 2014). The health facility is where most skilled attendants are available thus they can manage perinatal and maternal complications as they arise.

Some women had a positive attitude towards hospital delivery especially because of the potential risks when delivering with a TBA. This could be attributed to the availability of qualified staff in the health facilities who can handle and manage complications in case they arise. It could also be attributed to the previous positive experiences among the respondents. A study in Ghana established satisfaction of clients to maternal services provided in the health facilities (Speizer, Story, & Singh, 2014). Some of them still felt safe to deliver at home owing to the negative experiences in the health facilities. This could be attributed to negative staff attitude in the health facilities.

Quality of services offered by TBAs

Most of the clients who had experienced delivering with the TBAs appreciated their services. This could be attributed to demonstration of their competence in conducting the delivery. Also, the TBAs have a friendlier attitude as compared to health care providers as established in many studies(Akpabio, Edet, Etifit, & Robinson-Bassey, 2014; Emelumadu et al., 2014; Oshonwoh Ferdinand, Nwakwuo Geoffrey, & Ekiyor Christopher, 2014). Regarding fear of the services

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provided in the health facility such as HIV testing, this could be attributed to lack of confidentiality of information among the health care providers. Caesarean section was also feared by the participants thus made them seek TBA services. This could be attributed to the cultural esteem in a normal delivery where women who have a vaginal delivery re regarded highly whereas those who deliver by caesarean section are referred to as cowards. Inadequate explanation of the reason for performing the procedure could also be a reason for fearing caesarean section. A study in Zambia established similar findings that the quality of services offered at the clinic made most women to opt for home delivery (Sialubanje et al., 2015).

CONCLUSION

The community had mixed perception about TBAs. Men and women differed in their perception about traditional birth attendants. Factors such as affordability and accessibility contributed to positive perception of the TBAs, whereas the risk of complications was perceived negatively. TBAs provided good services as well as acted as birth companions making them attractive whereas the skilled care workers portrayed negative attitude towards their clients. Is it time the health care providers borrow an example from the TBAs? Future studies should be designed to get the perception of the TBAs about their services offered to the community members.

CONFLICT OF INTEREST

The authors of this article declare that there is no conflict of interest with the publication.

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Table 1: FGD guide

Question
What do you understand by TBAs?
What role do TBAs play in the community?
What services do they offer?
What is your perception towards them?
How do they compare to the health facility staff?

Table 2: Socio-demographic characteristics of respondents

Characteristic	Men	Percentage (%)	Women	Percentage (%)
Age				
• 15 – 19	2	5.3	7	16.7
• 20 – 24	8	21.1	13	31.0
• 25 – 29	7	18.4	8	19.0
• 30 – 34	5	13.2	6	14.3
• 35 – 39	3	7.9	5	11.9
• 40 – 44	3	7.9	3	7.9
• 45 - 49	2	5.3		
• 50 – 54	3	7.9		
• 55 – 59	3	7.9		
• 60 and above	2	5.3		
Education level				
• None	1	2.6	2	5.3
• Primary	12	31.6	23	60.5
• Secondary	17	44.7	14	36.8
• Tertiary	8	21.1	3	7.9
Occupation				
• Formal employment	8	19.0	5	13.2
• Self-employed	27	64.3	23	60.5
• Student	3	7.1	2	5.3
• Unemployed			12	31.6
TOTAL	**38**	**100**	**42**	**100**

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