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Traditional Birth Attendants and Childbirth in Kenya: A Case of Kitui West Sub County

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The first objective of this research was to explore the role played by traditional birth attendants (TBAs) during pregnancy and childbirth. The second objective was to establish perspectives of pregnant women regarding the role played by TBAs during childbirth. Eight TBAs out of 12 were selected using simple random sampling technique. These 8 TBAs were drawn from the environs of 10 sampled health facilities. To calculate the sample size for the pregnant women to be interviewed about their perspectives towards TBAs from the 10 sampled health facilities, this formula was used, 1230 x 15/100=184.5 rounded up to 185. According to 2009 census, the population of women at child bearing age (15 – 49 years) was 1230 in Kitui West Sub-County (KNBS et al.; 2009). The final sample size for pregnant women was 187 as shown under the discussion on sampling techniques. An in depth individual interview guide was used to gather information from the 8 TBAs and 165 pregnant women. Unstructured interview guide was used to gather information from 22 respondents who formed focus group discussion (FGD). To make a meaning from the raw data, it was transcribed and emerging themes and patterns according to the objective of the study were picked. The Chi-square test analysis showed that more than a half of the women preferred to deliver at home assisted by a TBA. ($\chi 2=1.572$; df=2; p=0.036) where p=0.05. This was confirmed by the fact that 37 percent out of 135 respondents who attended ANC clinic and 90 percent out of 30 respondents who did not attend ANC clinic delivered at home assisted by TBAs.

Keyword: TBA, pregnant woman, childbirth, delivery

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Traditional Birth Attendants and Childbirth in Kenya: A Case of Kitui West Sub County

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Abstract

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Key words: TBA, pregnant woman, childbirth, delivery

1.0 Introduction

TBAs undertake a vital role in communities where majority of women give birth at home. For instance in Asia, 41 percent of births take place at home assisted by TBAs (Falle, 2009). Pregnant women in Indonesia prefer to be assisted by TBAs instead of a skilled midwife because the latter are handy where resources are scarce to facilitate the woman to seek health facility delivery (Kumbani, 2013). Besides, TBAs offer psychological support, they are available and are good at empathizing with the women giving birth. Majority of women in the developing world prefer to give birth at home. For instance between 60 and 80 percent of deliveries take place at home assisted by TBAs. In Mexico TBAs conduct forty five percent of

deliveries at home (Ebuehi et al., 2006). In India, records of deliveries from health facilities indicated that majority of births happened at home with the assistance of a TBA (Milmo, 2013). In Sub Saharan Africa (SSA) approximately half of deliveries are attended by TBAs (WHO et al.; 2010). In Sierra Leone, TBAs conduct 70 % of deliveries and give support during antenatal period while in south-western Nigeria, TBAs conduct 65 % of deliveries at home (Ebuehi et al., 2006). In Uganda, majority of women, especially in the remote areas prefer to be assisted by TBAs during delivery (Tuguminize, 2009). In Kenya which is the country of study, 39 % of women deliver at home assisted by a traditional birth attendant (KNBS et al.; 2014).

1.1 Who is a Traditional Birth Attendant?

A TBA is a person among community members who conducts deliveries. This skill is acquired by observing other TBAs assisting deliveries or simply learned by doing. Since a TBA is an integral part of the community, she is aware of belief systems regarding childbirth in that specific community. She is an important person as regards to childbirth (Choguya, 2014). The role of a TBA therefore, should not be underestimated since she is the one who accompanies pregnant women to term. She plays the role of counselor and because of this relationship a bond is created whereby the pregnant woman entrusts her cares to the TBA concerning issues of childbirth. Usually it is the TBA who determines where the delivery will take place; either at home or in a health facility (ibid).

1.2 Research Objectives.

1. To explore the role played by TBAs during pregnancy and childbirth.
2. To establish perspectives of pregnant women regarding the role played by TBAs during childbirth

2.0 Study site

Kitui West Sub County which is the study site is one of the 16 sub counties in Kitui County. According to 2009 census, the population of women at child bearing age (15 – 49 years) was 1230 in Kitui West Sub-County (KNBS et al.; 2009). Health facilities were 261 with 3 County hospitals and 8 sub-county hospitals at the time of this research. According to the District Public Health Nurse in charge of the health facilities in Kitui West Sub County, there were 22 health facilities. Out of these facilities, 18 offered integrated maternal health care services.

3.0 Research methodology

3.1 Sampling technique

Out of 18 health facilities, 10 were selected using simple random sampling technique. Eight TBAs out of 12 drawn from the environs of the 10 sampled health facilities were selected using simple random sampling technique. To calculate the sample size for pregnant women within the 10 health facilities and their environs to cater for pregnant women who did not attend ANC clinic, the following formula was used 1230 x

15/100=184.5 rounded up to 185. This formula was based on the fact that, according to 2009 census, the population of women at child bearing age (15 – 49 years) was 1230 in Kitui West Sub-County (KNBS et al.; 2009). From each facility and its environs the researchers intended to interview 19 pregnant women which was arrived at by dividing 185/10 = 18.5, rounded up = 19 pregnant women. The researchers used the same formula of 15 percent to calculate the number of pregnant women who did not attend ANC clinic, thus; 19 x15/100 = 2.9, rounded up = 3 pregnant women from the environs of the sampled health facilities. However some of the health facilities were oversampled to compensate for the ones which had less numbers considering that the focus was women within gestation between 7-9 months which was a small segment among pregnant women. In the final end a total of 187 pregnant women were interviewed. These respondents comprised of 157 who attended ANC clinic and 30 who did not attend ANC clinic. The figure of 157 included; 135 respondents who were interviewed individually and 22 that formed FGD who were drawn from 2 health facilities within the 10 sampled health facilities. An in depth interview guide was used to gather information from individual respondents whereas unstructured interview guide was used to gather information from respondents who formed FGD.

To collect information from the TBAs to determine the role they played during pregnancy and childbirth, the following questions were asked:

1. Is there a time a pregnant woman plans to deliver in a health facility but later on changes and chooses to deliver at home?
2. According to your experience, can a pregnant woman deliver in a health facility against her husband's wishes to deliver at home?
3. Do you have prior link with pregnant women who come for delivery?
4. Are you aware of any problems that can occur during childbirth?
5. What happens in the event that the pregnant woman cannot deliver at home?
6. Do you give any advice about childbirth to pregnant/postnatal women when they come to see you?
7. In case there is a problem during labour or after delivery and family members are reluctant to take action, can you intervene?
8. Do you have further connection with the woman after delivery?
9. What do pregnant women say about delivering babies in a health facility?
10. Which category of women is likely to deliver at home and why?
11. Do you have any connection with nurses regarding your role as a TBA?

Individual pregnant women were asked; where they were planning to deliver their babies and where they finally delivered and the reasons for their choice. For FGD, the respondents were asked how they perceived the role played by a TBA during childbirth.

3.2 Data analysis

The raw data was transcribed to make a meaning. While emerging themes and patterns were identified, coded and categorized. To transcribe the raw data, the information was scrutinized and the main idea was

picked in relation to the objectives of the study. To interpret the data, qualitative and quantitative data was compared and validated. This was followed by indentifying concepts which were then grouped into themes according to the research questions. Finally, the information given was analyzed to explore the role played by the TBA during pregnancy and childbirth. Also the analysis included the perspectives of the pregnant women in respect of the role played by TBAs during childbirth.

4.0 Demographic characteristics of pregnant women

Women who attended ANC clinic

Respondents in the age bracket between 16 to 20 years were 25 out of 135(18 percent) while those in the age bracket of 21 to 25 and who were the majority totaled to 57(42 percent). The respondents who were between the ages of 26 and 34 were 44(33 percent). Respondents aged 35 and above were 9 (7 percent). Married respondents were 105(78 percent) while those who were single were 30(22 percent). One hundred and sixty three children were born within this category of women. Out of 163 children, 60(37 percent) were born at home assisted by TBAs. The rest of the children totaling to 103(63 percent) were the majority and were born in various health facilities. Analyzing the data further, it was observed that respondents within age bracket of 26-34 had delivered 31(37 percent) children at home assisted by TBAs out of all the children born totaling to 87. On the other hand those who were 35 years and above had delivered 21(70 percent) out of 30 children at home assisted by TBAs. These observations indicated that advancement in age coupled with childbirth experience was likely to influence women to deliver at home assisted by TBAs. These profiles of respondents are shown in table 1, page 6.

Table 1: Demographic characteristics of pregnant women

		N.	Percentage
Age	16-20-years	25	18
	21-25-years	57	42
	26-34-years	44	33
	35 & above years	9	7
Total		**135**	**100%**
Marital status	Married	105	78
	Single	30	22
Total		**135**	**100%**
Education level	No schooling	1	0.7
	Primary	86	63.7
	Secondary	39	28.9
	Tertiary	9	6.7
Total		**135**	**100 %**
Religion	Catholic	45	33
	AIC	41	30
	Pentecostal churches	49	37
Total		**135**	**100%**
Gestation period	7 months	43	32
	8 months	49	36
	9 months	43	32
Total		**135**	**100%**
Previous pregnancies	1st pregnancy	50	37
	1 – 2 children	63	47
	3 – 5 children	20	15
	6 – 8 children	2	1
Total		**135**	**100%**
Birth place of 163 children born to women interviewed	Home deliveries	60	37
	Health facility deliveries	103	63
135	**100%**	**163**	**100%**
Occupation	Small businesses	21	16
	Teachers	15	11
	Subsistence farming	58	43
	Housewives	15	11
	No occupation	26	19
Total		**135**	**100%**

Demographic characteristics of pregnant women

Women who did not attend ANC clinic

The respondents in the age bracket between 18 to 25 years were 8(27 percent) while those in the age bracket of 26 to 34 and who were the majority totaled to 12(40 percent). Respondents aged 35 and above were 10.

Married respondents were 25(83 percent) while those who were single were 5(17 percent). The Number of children born by 26 respondents was 89. The largest number 81(91 percent) was born at home assisted by TBAs while a small number, 8(9 percent) was born in various health facilities. The distribution of the respondents' characteristics of respondents is illustrated in table 2 below.

Table 2: Demographic characteristics of women who did not attend ANC clinic

4.1 Findings

Results

Interview with TBAs

		No.	Percentage
Age	18-25 years	8	27
	26-34 years	12	40
	35 years & above	10	33
Total		**30**	**100%**
Marital status	Married	25	83
	Single	5	17
Total		**30**	**100%**
Education level	Primary	23	77
	Secondary	7	23
Total		**30**	**100%**
Religion	Catholic	10	33
	AIC	8	27
	Other denominations	12	40
Total		**30**	**100%**
Gestation period	7 months	6	20
	8 months	11	37
	9 months	13	43
Total		**30**	**100%**
Previous pregnancies	1st pregnancy	4	10
	1 – 2 children	10	33
	3 – 5 children	13	47
	6 – 8 children	3	10
Total		**30**	**100%**
Birth place of 89 children born to women who did not attend ANC clinic	Home deliveries	81	91
	Health facility deliveries	8	9
Total		**30**	**100%**
Occupation	Small businesses	17	57
	Subsistence farming	6	20
	Housewives	4	13
	No occupation	3	10
Total		**30**	**100%**

Most of the respondents' responses were reported verbatim and the respondents were given pseudonyms to conceal their identity.

The following discussion highlighted the role played by TBAs during pregnancy and childbirth. To elicit responses the researchers used some questions as indicated below:

Is there a time a pregnant woman plans to deliver in a health facility but later on changes and chooses to deliver at home?

All the 8 respondents said that it was likely for a pregnant woman to plan to deliver her baby in a health facility and later change and deliver the baby at home. For instance Ng'anduna said:

> Yes it happens, sometimes labour can be precipitated and alter original plans of delivering in a health facility hence making the woman to deliver at home. There are other women who deliver on their way to a health facility. Some pregnant women can decide to deliver at home assisted by a TBA but if the TBA realizes that delivery cannot take place at home due to difficult labour, the pregnant woman is taken to a health facility by her relatives. A case in point was a woman whom I was assisting during childbirth. As I assisted this woman, I realized that labour was not progressive as expected. As a result of this experience, I accompanied her to the health facility where she underwent caesarean section because the baby's cord had coiled around the neck.

Additionally, Ng'atuva, one of the respondents shared her experience as indicated in the following extract:

> A woman might also change her mind to deliver at home instead of delivering in a health facility because of cordial relationship with the TBA and family members. Nevertheless, if complications arose during labour there was no option but to seek assistance in a health facility. For example, one of my clients had planned to deliver in a health facility but during labour she asked me to conduct the delivery. In the process, I realized that she was experiencing difficult labour so I decided to accompany her to the health facility where she delivered safely.

Ng'akalungu concurred with Ng'atuva and Ng'anduna that, it was likely for a pregnant woman to change her plan of delivering her baby in a health facility and opt to deliver at home. As she put it, "Women plan to deliver in a health facility but change to deliver at home because the home environment is favorable since there is support and concern by relatives. Some women will choose to deliver in a health facility when they realize that there is a problem that cannot be handled at home". Ng'andike and Ng'anzula held the opinion that, some pregnant women would change their plans of delivering their babies in a health facility because they thought TBAs were experienced and felt safe in their hands.

The respondents were asked if a pregnant woman could deliver in a health facility against her husband's wishes to deliver at home.

Ng'anduna, agreed that a pregnant woman could deliver in a health facility against her husband's wish. She cited a case where a husband insisted that his wife should be assisted by a TBA but the wife wished to deliver in a health facility. She said, "The pregnant woman came to my house and I walked her to the health facility. I stayed with her in the health facility for 2 days till she gave birth and was discharged", concluded Ng'akalungu. However, Ng'akulikya maintained that the woman could deliver her baby in a health facility but the TBA had to intervene to persuade the husband to accept the wife's choice. Notwithstanding the views of the above respondents, the rest 5 disagreed with the above views and firmly maintained that a woman could not possibly go against her husband's wish. For instance, Ng'amuli affirmed that a married woman could not go against her husband's decision.

To elaborate this further, she cited the following case:

> A certain pregnant woman planned to deliver in a health facility but the husband refused to let her do so. She packed a few of her belongings and came to ask me to accompany her to the health facility. Since I did not want to cause a conflict in her family, I urged her to comply with her husband's directives. However I prepared her on how to await for the baby by having a new razor blade, clean cord ligatures for tying the baby's cord, a clean mattress and a clean bed sheet. I advised her to ensure that the baby's cord was tied 3 times and demonstrated to her how to separate the cord from the placenta. I also demonstrated to her how to deliver the placenta and how to examine it to ensure that there were no retained pieces of placenta in the uterus. The pregnant woman went back to her house and when she realized that she was about to deliver, she informed the husband and requested him to call a TBA. The husband went and never came back until the following morning without a TBA. Fortunately she delivered safely all alone at night.

Although Ng'andike felt that a pregnant woman cannot go against her husband's wishes, she believed that she had an obligation to convince the woman's husband to allow his wife to deliver in a health facility as she wished. Ng'anzula sharing similar views as well indicated that, though she believed a pregnant woman could not go against her husband's wish, she felt she could intervene in case of a need to facilitate the pregnant woman's referral to a health facility.

Do you have prior link with pregnant women who come for delivery?

Ng'andike and Ng'amuli pointed out that they had contact with pregnant women prior to conducting the deliveries. But they lamented that there were those women who came the last minute. For instance Ng'andike said, "I have contact with pregnant women, but there were those who came the last minute which was not good. When pregnant women come unexpectedly I might not know the position of the baby or the health status of the woman. When the position of the baby in the uterus and the health status of the woman are not known in advance, any advice given thereof can be limiting". Sharing her views on the same matter, Ng'amuli postulated that although she made contact with pregnant women, it was not on

regular basis. She observed that some women came only when they were in labour but she assisted them. "It did not matter if we had any prior interaction or not, it was all about delivery", she said.

The rest of the respondents, like Ng'amuli, did have contacts with pregnant women but not always. Ng'anzula pointed out that sometimes women came when they were in labour and she assisted them. But she usually preferred to have women who had frequently been coming to see her because at least she knew their situation better that was; the position of the baby in the uterus which gave her an idea of the type of delivery expected. She further observed that for the pregnant women who only came during labour, she could not know their condition in terms of the position of the baby in the uterus and the wellbeing of the woman. She shared a case of a woman who did not have prior contact to demonstrate how challenging the situation could be:

> I was called by relatives to assist a certain woman who was in labour. This woman had never come to see me before regarding her pregnancy. All the same I agreed to conduct the delivery because she was about to give birth. This woman had no money for transport in case of any eventuality, no clothes for the new born neither was there any food in the house. Little did I know that she was expecting twins which are usually complicated to deliver at home. The first twin was born without complications and survived but the second was born asphyxiated (difficulties in breathing) and died immediately after birth. The placenta was retained and the woman started bleeding excessively. Although I was able to deliver the placenta, the woman died immediately after that because she lost a lot of blood.

Four other respondents shared similar concerns with the above respondents regarding irregular contacts with pregnant women. These respondents maintained that their first contact with some pregnant women was when they were in labour or ready to give birth. Despite what has been said above, Ng'akalungu did not have any link with the pregnant women because she did not conduct deliveries anymore. She pointed out that TBAs were discouraged not to conduct home deliveries by Ministry Of Health, Kitui due to HIV/AIDS scourge. Nevertheless she conducted emergency deliveries to save life.

What happens in the event that the pregnant woman cannot deliver at home?

Ng'atuva and Ng'amuli would inform the mother in law who was expected to contact the husband of the woman who was in labour to organize for transport or come to a consensus on what to do. If the woman was not married Ng'amuli would take a step further and inform her mother to organize the logistics of going to a health facility. Ng'andike on the other hand would share the problem with the husband because he had the final say about what was to be done next. "In some cases I have realized that neither the pregnant woman nor the husband have prepared for any emergency. I have observed that they start borrowing money for transport when the woman was really in danger", she said. Ng'akulikya shared similar views by contending that many a times the woman including family members were not usually prepared for such eventualities because sometimes it took quite a while to get money for transport.

Ng'anduna and Ng'akulikya said that they would inform the family members; give them the reasons why the woman could not deliver at home and accompany the woman to a health facility. For Ng'akalungu, she would give the report to the relatives of the pregnant woman so that they organize for transport if the health facility was far. "Otherwise if transport was not available and the health facility was within reach, I and the relatives of the pregnant woman, we would walk with her slowly to the health facility. Sometimes I use my own resources if I find that the woman had not saved any money for contingency" said Ng'akalungu. If the woman could not deliver at home, Ng'andeveimwe would refer her to a health facility or call the nurse to come for assistance. "However referral in such a context has its challenges. It is possible to refer the pregnant woman to a health facility only to discover that she was not prepared for such an eventuality. This is evidenced by the helter - skelter way of doing things and sometimes life is lost" she said.

Do you give any advice about childbirth to pregnant/postnatal women when they come to see you?

Ng'anduna and Ng'akalungu had elaborate accounts on the advice they gave to pregnant women. For instance Ng'anduna advised antenatal women on personal hygiene, the best sleeping position to avoid making the fetus uncomfortable, to avoid strenuous work and to avoid standing for long hours. If her legs were swollen, she took silks from green maize, boiled it and gave the fluid to the woman to treat the condition. She palpated the abdomen of the woman to know how the fetus was lying in the uterus. In case she found the fetus was mal-positioned, she performed manual positioning to bring the fetus to a normal position. She also listened to the foetal heart. Ng'anzula also palpated the women and gave them advice about personal hygiene and eating balanced diet such as beans and maize. Ng'akalungu encouraged antenatal women to attend ANC clinic and examined them to check if they were anaemic. Her full account was captured as under:

> In the case of anaemia, I advised the woman to eat more of nutritious food such as milk, meat, vegetables, eggs, beans and fruits. For swollen legs, I advised her to rest her feet on an elevated position like on a stool to increase blood circulation. If a woman had varicose veins, I referred her to a health facility because there was a danger of bleeding profusely if the veins were pricked.

Like Ng'anduna and Ng'akalungu, Ng'andeveimwe advised antenatal women about the best position of sleeping to avoid stressing the fetus. Like Ng'anduna, Ng'andike also palpated the pregnant woman's abdomen to ascertain the position of the fetus and then advised the pregnant woman accordingly. Ng'atuva on the other hand advised antenatal women to save some money for transport in case of any emergencies such as early ruptured membranes. Ng'akulikya informed pregnant women that ruptured membranes was a dangerous sign in pregnancy since it could cost the baby's life and gave them the signs of how they would recognize this condition.

Ng'amuli advised postnatal mothers to drink milk after delivery to relieve abdominal pain which occurs after delivery. Ng'anduna taught postnatal mothers about personal hygiene, the type of food (milk, beans, meat, maize, sorghum, and finger millet) they should eat in order to increase blood supply in the body to replace what was lost during delivery and to increase breast milk. She further advised them to exclusively

breast feed the baby for six months. She explained the postal mother that breast milk was the best for the baby. She told her to keep the baby warm at all times in order to avoid pneumonia as well as keeping the baby clean. Ng'akalungu also advised the postnatal women to keep the baby warm always. She taught them the best way to position the baby while breastfeeding and to exclusively breastfeed it for six months. She recommended them to feed well in order to increase breast milk.

Ng'andeveimwe she advised postnatal women against holding the baby upside down. She also advised them to avoid bathing the baby few days after delivery and only use cotton wool dipped in oil to wipe the body and to keep it warm all the time. Similar ways of bathing the baby and keeping it warm as mentioned above were also shared with pregnant women by Ng'andike. Ng'andike advised postnatal mothers to take panadal tablets in case they were in pain and she taught them how to keep the baby warm while Ng'akulikya listened to their complaints and advised them accordingly.

In case there is a problem during labour or after delivery and family members are reluctant to take action, can you intervene?

In answer to this question, Ng'andeveimwe shared her experience of such situation as under:

> A certain pregnant woman whom I had not known in advance came to me when her time for delivery was due. After a brief examination I realized that I was not able to conduct the delivery. When I brought my concern to the family members they seemed not to bother. Faced with this situation, I decided to take the responsibility and accompanied the woman to a health facility where she eventually delivered safely.

Four other respondents said they would involve mothers in law, husbands or parents and make sure the pregnant woman was taken to a health facility. For instance, 4 respondents concurred that they would talk to a family member especially mother in law and the husband or the parents if the woman was not married and inform them why the pregnant woman should be taken to a health facility. In case they refused to take action, Ng'anduna would involve the village administration although she has never involved the village administration because the family members usually listened to her. Ng'atuva would involve the village elder and the chief if need be if no action was taken. If no foreseeable action was forthcoming the four respondents indicated that they would use their own resources. In this regard Ng'anduna said, "If the family members are not supportive especially when the husband disowns the pregnancy, I will use my own resources to help the woman but we agree on how she will refund whatever money I spent". Ng'akalungu shared the same views with Ng'anduna. She pointed out that if family members were not willing to transfer the pregnant woman to a health facility, she would use her own resources to ensure that she got to a health facility for help. Later she would negotiate with the parents on the modalities of paying back her money. Ng'atuva would also use her own resources to assist the woman. She did not talk of reimbursement of the money she would have used to help the woman.

Ng'andike said she would inform the family members about the situation and insist to be told what should be done while Ng'anzula would do everything to ensure that the mother and the baby's lives were safe. She postulated that, "a TBA was powerful and family members would listen to the advice given by her". Out of the 8 respondents, one said that she would leave the matter to the family members to make a decision so as to avoid being part of any consequences thereafter while the rest maintained that they would persuade family members to take appropriate action.

Do you have further connection with the woman after delivery?

Ng'anduna said that she followed up the woman after delivery to demonstrate to her how to bathe the newborn if it was the first baby. She encouraged the woman to observe personal hygiene in order to avoid any infection to herself and to the baby. Ng'anduna established the kind of food the woman was eating and gave advice where necessary concerning eating balanced diet. On the same discussion, Ng'akalungu, Ng'atuva, and Ng'andeveimwe said that they followed the women after delivery to ensure that the mother and the baby were feeding well. They examined the umbilical cord to make sure that it was properly tied and clean and if there were any signs of infection. They checked if the baby was kept warm and whether there was any sign of coughing or restlessness. On the contrary, Ng'anzula, Ng'amuli Ng'andike and Ng'akulikya did not maintain any contacts with their clients for various reasons. Ng'akulikya said that she did not have any further link with the women she assisted during delivery because she was afraid that further association with these women would be construed by the family members to imply that she was looking for alms from them. Ng'andike only enquired about the woman and the baby from her relatives when they encountered each other along the road. Ng'amuli said, "Unless the woman comes back to consult me, I have no further connection with her" while, Ng'anzula simply said that there was no further link with the woman after delivering the baby without making further comments.

What do pregnant women say about delivering babies in a health facility?

According to one of the respondents, most pregnant women preferred to deliver at home because they felt supported by their relatives and friends during childbirth. As she laments, "In contrast, pregnant women claimed that they were left alone in the labour ward, and the nurses told them to call them when they were ready to deliver. Sometimes these women called the nurses and the latter were nowhere to be found", said Ng'anduna, Ng'akalungu and Ng'akulikya shared similar sentiments about the nurses' negative attitude towards pregnant women with Ng'anduna. Ng'akalungu indicated that the relationship between the nurse and the woman in labour was not warm.

Ng'akalungu contributing on the same issue contended that, "Most women prefer to deliver at home because there is support from relatives and the traditional birth attendant. The support includes massaging, provision of warm drink during and after delivery". Contributing further to the above discussion, Ng'akulikya, Ng'anzula, Ng'andike and Ng'amuli said, women preferred to deliver at home where there was support and tender loving care from the TBA and other relatives.

What the 8 TBAs said regarding the attitude of nurses when women seek delivery in a health facility was likely to influence their choice of place of delivery. The Chi-square test analysis ($\chi 2=9.215$, df= 2, p=0.010) confirmed these sentiments by the respondents by indicating a strong correlation between negative attitude of medical staff and choice of place of delivery. Negative attitude of nurses towards pregnant women was also noted by Kumbani et al. (2013). These researchers conducted an investigation in Southern region of Malawi in the Chiradzulu district to explore why some women fail to give birth in health facilities. Their study revealed that one of the reasons why women did not deliver their babies in a health facility was the unfriendly attitude of nurses towards them. Their respondents said they were shouted at and yet they expected to be treated with dignity.

Do you have any connection with nurses regarding your role as a TBA?

Five of the respondents; Ng'anduna, Ng'akalungu, Ng'akulikya, Ng'andeveimwe and Ng'anzula had contact with nurses. Ng'akulikya said that, when a pregnant woman faced any challenges during labour; she accompanied her to a health facility and handed over the case to the nurse. Many times she took pregnant women to the health facility to be assisted to know the position of the fetus which was very important because during delivery the head of the fetus should be presenting. Ng'akalungu and Ng'andeveimwe had similar views about their contact with the nurse. When they accompanied pregnant women to a health facility, the nurse taught them about their roles as traditional birth attendants and the need to refer pregnant women to a health facility where there was good care and trained medical staff. Ng'anduna made contacts with the nurse in case of a problem because the health facility was within reach while Ng'anzula was advised accordingly by the nurses that, if there was any problem regarding pregnant women she should accompany them to the health facility. Interestingly, the other 3 respondents; Ng'atuva, Ng'andike and Ng'amuli had no connection with nurses. Ng'amuli said that she did not have any connection with nurses even when she accompanied pregnant women to a health facility. She revealed that she did not identify herself as a TBA to the nurses because the Ministry Of Health had forbidden them from practicing their trade. Ng'andike had no connection with the nurses since she was not trained while Ng'atuva simply said she had no connection with nurses and did not want to talk about the issue.

Interview with pregnant women

Results

The research results indicated that, 126(93 percent) respondents out of 135 among those who attended ANC clinic had planned to deliver in a health facility. Nevertheless only 86(64 percent) out of 135 respondents delivered their babies in a health facility and the rest 49(36 percent) delivered at home assisted by TBAs. Out of the 30 respondents who did not attend ANC clinic, 18(60 percent) had indicated that they would deliver their babies at home. Six (20 percent) out of 30 respondents had indicated that they would deliver in a health facility. Surprisingly only 3(10 percent) respondents out of 30 delivered in a health facility and the rest 27(90 percent**)** delivered at home assisted by TBAs.

Confidence in the TBA

Seven (5 percent) respondents out of 135 who attended ANC clinic and 7(23 percent) out of 30 who did not attend ANC clinic delivered at home because of the confidence they had in TBAs after being assured by the latter that normal delivery was possible. Although, Mwikali had previously lost a baby during delivery at home, surprisingly, she still gave birth at home assisted by a TBA without any recourse to her previous loss under the patronage of a TBA. Nonetheless according to Mwikali, the death of her previous baby was God's design and it had nothing to do with the place of birth or the TBA conducting the delivery. However this time she delivered without any problem.

Nthoki seemed to have had real faith in TBAs, because she had been advised by the nurse to deliver in a health facility. Interestingly she chose to deliver at home when the TBA assured her of a safe delivery at home. Against all odds, she delivered safely. Kamene delivered also safely at home assisted by a TBA who she had confidence in. Ndini was contemplating delivering in a health facility until labour pains began. In her narration she said, "To avoid logistics of going to a health facility, when labour pains began I requested my husband to call a neighbor who was a good TBA. I was convinced that I was going to deliver normally without a problem since I never experienced any problems during my last delivery. As anticipated I delivered without problems".

Velesi on her part also narrated her experience during childbirth, she said:

> The membranes ruptured early and the amniotic fluid drained out and I started bleeding, but I was confident all would be well. The TBA and my mother in law massaged my abdomen with coconut oil and administered some herbs to induce labour pains. After sometime I experienced strong contractions and gave birth and the bleeding stopped.

Even though, 2 respondents among those who were assured by the TBAs of safe delivery at home, experienced childbirth challenges (excessive bleeding) as they attempted to give birth at home. For instance, Mbeneka was 36 years old with 2 children, one of which was born at home and the other one in a health facility without problems. According to the respondent, the TBA had assured her of a safe delivery at home. Unfortunately after giving birth she started bleeding excessively because the placenta was retained. The TBA managed to deliver it after sometime and the bleeding eventually stopped. Mbinya suffered from excessive bleeding after delivering because of retained placenta too. According to the respondent, the TBA and the mother in law put a tip of a rope in her mouth to enforce her to vomit so that the same force could exert pressure to expel the placenta. This happened and the placenta was expelled and the bleeding stopped.

Mumo aged 38, described her ordeal during childbirth in the following text:

> I have delivered all my 8 children at home successfully with encouragement from my husband. My husband always brought a TBA to conduct my deliveries. But I really wanted to deliver this baby in a health facility as I was advised by the nurse on account of my age. But I did not see the need

> of delivering in a health facility when the TBA assured me that the position of the baby in the uterus was okay since the head was presenting and progression of labour was fine. I began bleeding excessively immediately after birth. I was given a mixture of 'omo'(powder soap) and water and some concoction to drink in order to arrest the bleeding which worked. But I felt dizzy and weak after this. I was accompanied by my mother in law and my husband to Kitui County hospital where I was transfused blood because I was anaemic.

Mukulu aged 32, one among the 7 respondents had delivered 6 of her 8 children at home without complications. The 2 previous children delivered in a health facility were as a result of prolonged labour at home and the respondent was transferred to a health facility by the TBA. This respondent maintained that she was assured by the TBA that safe delivery was possible since the position of the baby was okay. She delivered at home without any problem.

Kakulu aged 38, also had delivered all her 7 children at home without any complications. Despite the fact that she had been advised by the nurse to deliver in a health facility, she finally delivered at home after the TBA observed that progression of labour was fine. Kutu aged 35 years had delivered her 4 children at home without complications with assurance from the TBA. This respondent delivered at home after being assured by the TBA that safe delivery was possible. Mutunge aged 28, single and was expecting her first baby, although she had attained secondary level of education, her mother convinced her to deliver at home under the care of the renowned village TBA who was her best friend. This respondent complied with her mother's plea and delivered at home. The remaining 2 respondents all gave birth safely at home after the assurance from the TBA that home delivery was possible.

Mbaluta who was 34 years old, had previously delivered one child at home. Though she had intended to deliver in a health facility when the TBA assured her of a normal delivery, she changed her mind and decided to deliver at home. Unfortunately after delivery, the baby did not cry immediately after birth. The TBA and the mother in law 'banged tins' hoping the noise produced would make the baby to cry. This method did not work. The last option was to splash cold water on the baby which worked. Kyale also chose to deliver at home simply because she believed that under the patronage of a TBA, she was assured of safe delivery.

Referral by TBA during childbirth

Seventeen (13 percent) out of 135 respondents who attended ANC clinic and 3(10 percent) respondents out of 30 among those who did not attend ANC clinic were transferred by the TBA in the process of childbirth. This action by the TBA clearly demonstrated the role she played by referring difficult cases to a health facility.

The remaining 131 respondents out of 165 that is, 135 who attended ANC clinic and 30 who did not attend ANC clinic were influenced by different factors in choosing place of delivery. For instance 57 were influenced by significant ones, 29 had the autonomy of choice, 22 had previous safe deliveries, 13 experienced previous complications during childbirth, 5 were aware of benefits of delivering in a health facility, 3 had precipitated labour while 2 delivered in a health facility because TBAs refused to conduct

deliveries because of HIV/AIDs scourge.

Results from FGD

This discussion took place in two health facilities where 12 and 10 respondents were interviewed. The general view of these respondents was that, due to the role played by a TBA in influencing the choice of place of delivery, her position could not be overlooked.

5.0 Conclusion

Confidence in the TBA

According to the research findings 14(9 percent) out of 165 respondents delivered at home because of the confidence they had in TBAs after being assured by the latter that normal delivery was possible. Although, one of the respondents had previously lost a baby boy while delivering at home, surprisingly, she still sought services of a TBA claiming that death could happen anywhere because it was God's design. Another respondent defied the advice of the nurse against delivering at home. Besides the advice given by the nurse, the TBA had confirmed to her that the position of the baby in the uterus was okay and normal delivery was feasible. One respondent had full confidence in the TBA. When the membranes ruptured early and the amniotic fluid (the fluid that surrounds the fetus in the uterus to facilitate mobility) drained out and she started bleeding, the obvious thing to do was to organize for immediate transfer to a health facility because this was an emergency. Instead, she believed the TBA and her mother in law would manage the situation. The centrality of a TBA especially among the rural communities is associated with the highly valued social role they played in the communities (Owino and Legault 2013). They offered emotional support and continuity of care in comparison to the type of care that was made available at the health units. For instance, TBAs in Maasai usually go together with pregnant women to antenatal clinics, examine them at home, and refer them to health units for care if they identify a potential problem, otherwise during normal delivery TBAs stay with women giving birth through labour and up to five days post-partum (Magoma et al., 2010).

On the other hand, TBAs satisfy the expectations of the pregnant women which include; continual support and advice during pregnancy, delivery, and in the postpartum period, the provision of body massage throughout labour and delivery, and knowledge of a variety of delivery positions (Magoma et al., 2010). All these good tidings by the TBAs build a strong faith and confidence among the pregnant women who receive their services. Adding voice to this discussion on confidence on the TBAs, Rahmani and Brekke (2013) maintain that TBAs were popular because they were not expensive as they were paid in kind, they were tolerant and kind, and spent more quality time with pregnant women. Supporting the views of Rahmani and Brekke, Agus and Horiuchi (2012) pointed out that, some of the women they interviewed didn't have confidence in the new village trained midwives because they were often young, unmarried, and inexperienced. Respondents interviewed in this study had similar views as Agus and Horiuchi. For instance one of the respondents interviewed in this study said, "I am too old to be assisted by a young midwife in a health facility". While another said, "I feel safe to be assisted by a TBA". "So long as the TBA confirms

that the position of the baby in the uterus was okay and normal delivery was possible, delivering at home where the environment was conducive was preferred to a health facility," one respondent asserted. "Hospitals are for referrals and it was okay to deliver at home," said one other respondent.

Agus and Horiuchi (2012) further maintained that, TBAs displayed overt interpersonal skill, special care, and respect for local customs which could not be exemplified by village midwives who were viewed as too young and inexperienced, whereas TBAs were more mature, patient and caring compared with the trained midwife. In Butajira district of Ethiopia, women preferred to deliver at home assisted by TBAs because members of the family were allowed to be with her during labour and delivery which was consoling (Roro and Hassen 2014). These findings of Roro and Hassen were in line with what some of the respondents in this research observed. For instance one of the respondents said; I chose to deliver at home instead of delivering in a health facility because of the cordial relationship I have with the TBA and my family members".

This research revealed that a TBA had a profound role to play regarding childbirth. Apart from conducting deliveries, a TBA had multiple roles such as healing. For instance, this research indicated that a TBA was able to contain bleeding after delivery, administered herbs to hasten delivery process and managed to remove retained placenta. In the same way, a TBA had the privilege to decide whether a woman should deliver at home or in a health facility. According to this research, 20(12 percent) respondents out of 165, that is, 17 from those who attended ANC clinic and 3 from respondents who did not attend ANC clinic, were transferred to a health facility by the TBA during the process of childbirth after realizing that delivery was not possible at home.

Recommendations

Having ascertained the insightful role of the TBA, it would seem unwise to abandon the maternal services of a TBA since there was good evidence advanced in this research supporting their vital role among community members. Based on the confidence communities have in TBAs, there is therefore the need to train the latter in basic skills in order to give standardized maternal health care services. After training, TBAs could be allowed to conduct deliveries alongside nurses to learn new skills that they probably did not have. This collaboration could include follow up visits to support the TBAs in order to find out if there were any gaps that might require further input. During this time of follow up, the TBAs could also be encouraged to refer risky cases in good time to a health facility for further management.

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