EXPLORING THE MOTIVATIONS OF BIRTH COMPANIONS

A QUALITATIVE ASSESSMENT

Maternal and New born Health Improvement Project

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Abstract

High mortality rates in rural Kenya are mostly linked to women giving birth at home with the help of Traditional Birth Attendants (TBAs). TBAs do not have medical skills and help mothers and newborns with very limited resources. TBA work has been strongly discouraged by the Kenyan Ministry of Health for many years, but the practice has continued. The MANI (Maternal and Newborn Health Improvement) project, implemented among its interventions the transition of Traditional Birth Attendants (TBAs) to Birth Companions (BCs). The focus of the intervention is to stop TBAs from helping mothers to give birth at home and instead, to encourage them to go to the health facility for antenatal appointments, and accompanying them to give birth under professional care. By October 2017, the MANI project had supported the reorientation of 305 TBAs into BCs and then decided to carry out a qualitative study to understand the different motivations, dynamics and incentives linked to the BC practice. This report gathers and analyses the experiences of 176 project participants, most of them reoriented BCs, plus the experiences of a smaller group of mothers and health workers. Through a focus on qualitative data gathered from focus group discussions (FGD) and key informant interviews (KII) we learned that the transition has brought BCs significant non-material gains such as respect and recognition from their communities, health facilities' front-line staff and, importantly, from their husbands. Among the top reasons for BCs to make the transition were the desire to reduce mothers and babies' deaths and to stop being engaged in a banned practice. Among the negative aspects of the transition, the BCs reported loss of income and some problems with transport to accompany mothers in labour to the health facility. There were other interesting findings such as real or perceived negative attitudes of health professionals towards mothers, and sometimes to BCs themselves. These can act as a true barrier for the sustainability of the project and need to be addressed. This research has similarly raised a number of new questions, and potential areas for further research such as: adoption at health centres of alternative and more culturally appropriate birthing positions; identifying if there are potential health risks in the traditional massages provided by former TBAs to pregnant mothers; and advantages and feasibility of allowing BCs in the labour room to provide non-clinical support to the mother in labour and to fully fulfil their role as Birth Companions.

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1. Introduction

Rural areas in Western Kenya have some of the highest rates of maternal and newborn mortality in the world. More than half of women give birth at home without skilled care and with no resources. This is believed to be a significant contributing factor to maternal and newborn mortality. Access to health services depends on where women live, their socio-economic status and access to transport. The MANI (Maternal and Newborn Health Improvement) project aims to increase the survival of mothers and newborns by improving access to health services and promoting innovation for better care. To achieve its aims, MANI is strengthening health systems; increasing demand for services and funding innovative projects delivering local solutions to local problems.

The MANI project has been implemented by a consortium led by Options since 2015, working in partnership with a number of organisations, including CARE (CARE International UK and CARE Kenya), MSI, Mannion Daniels, IHPMR, AMREF Health Africa, Population Council and KPMG.

One of the MANI project's interventions focuses on training and reorienting Traditional Birth Attendants (TBAs) in Bungoma county, to become Birth Companions (BCs). TBAs are women who help mothers in the village to give birth at home. TBAs receive payment from their customers, either in cash or in kind. This is a vocational job which they perform without having been medically trained. They generally use skills learned from relatives and friends.

The reorientation of TBAs into BCs in rural and/or low-resource settings has been documented and explored by both policy-making institutions such as the World Health Organisation as well as organisations working on maternal health in developing countries. In the early 1980s, the WHO developed a curriculum used to equip TBAs with knowledge to support deliveries occurring at home. The worsening maternal and neonatal indicators prompted a change in the WHO policy in 2000, encouraging countries to stop TBAs from conducting deliveries at home. The Government of Kenya through their Reproductive Health Policy of October 2007, affirmed this position, discouraging TBAs to continue with their work and stating that they are not recognised as providers of health care. In spite of this, women in the rural areas carried on delivering at home with the help of TBAs. Maternal and newborn mortality indicators in Kenya continued to worsen, making the country off track to meet millennium development goals (MDG) 4 and 5 in 2015.

The MANI project, as part of its efforts to increase demand for health services, supported the transition of TBAs to become 'Birth Companions' – increasing their knowledge and skills through training, giving them a role in referring and accompanying women to nearby facilities, and providing pregnant women with a mix of the personal and professional care that they need and want.

Birth Companions training consists of initial 3-day intensive sessions with BCs in which topics such as: status of maternal and newborn health in the local area; maternal and newborn health services available; role of BC to link pregnant women to these services; good nutrition for mothers, supplements and hygiene during pregnancy; importance of breastfeeding and basic communication, advocacy and networking skills.

Trained Birth Companions are supported by monthly review meetings and additional, shorter training sessions for a year. The Birth Companions work within the existing community structures and within the Community Health Unit catchment areas. They are linked to nearby health facilities for purposes of referrals. The BCs therefore, play complementary roles to the Community Health Volunteers (CHV) , as referral agents, birth and post-natal companions, nutrition advocates, hygiene promoters, and ensuring that births are registered.

To allow trained Birth Companions to deliver their new role, the project provided BCs with basic kit, including gumboots, a torch and a MANI Birth Companion shirt.

One of the biggest challenges for this transition was that the new Birth Companion role implies a loss of income (in kind or cash) for BCs. The MANI project decided not to offer a fee to BCs for referrals of mothers to health facilities and the facilities themselves do not generally provide this. Cognisant of this loss of income, MANI set up an additional intervention for the Birth Companions, the "Village Savings and Loans Associations (VSLA)". VSLAs are CARE's successful model to provide the first step of access to financial services such as savings and credit. The VSLAs supports the formation of savings groups at community level. Later on, loans from the cash being saved by the group can be made to members of the group, according to rules agreed within the group. The groups are typically composed of 15 to 30 people. At the end of a pre-determined period, usually a year, the members share out all or most of the group's accumulated capital to the members, before beginning a new cycle. BCs who have been included in VSLAs received 3 days of training on the VSLA model and a further 2 days training on how to start income generating activities.

While 305 TBAs have willingly participated in the reorientation programme, and the new role has been performed with enthusiasm, it is vital for the sustainability of the initiative that we understand the different dynamics of motivations and incentives linked to the new practice.

In order to learn more about these, the MANI project, undertook research to explore the reasons that encourage BCs to continue practicing their new role and to find out if it seems likely that they may be drawn back to their previous role as TBAs.

This paper presents the findings from the research.

2. Methodology

This qualitative study covered six sub-counties of Bungoma namely:

1. Kanduyi Sub County
2. Kabuchai
3. Sirisia
4. Tongaren
5. Webuye East
6. Webuye west

It focussed primarily on BCs' personal motivations and experiences aiming to:

1. Better understand the motivations of BCs to embrace their new role.
2. Recognise the role of monetary and non-monetary incentives in the choice to become and remain a BC.
3. Learn how the BCs retrained under our project experienced the transition of moving from being a TBA to a BC.
4. Explore any other unplanned changes in relationships and practices within the communities that might have emerged during the course of the project that may influence its success either positively or negatively.

The data collection was conducted with the help of a small research team, four local research assistants, all female, as are the BCs themselves, and 2 coordinators. The interviews were conducted in Kiswahili and occasionally a local language (Lubukusu). The research assistants worked in teams of two, facilitated discussions and exercises and taking extensive notes, that included body language, tone of voice and reactions to comments by the rest of the group. (The sessions were also recorded for reference). Subsequently the research assistants typed the entire transcripts in English including observation notes into purposely created templates for the data analysis.

Two main techniques were used in this research for data collection: FGDs and KIIs. During the FGDs and KIIs with mothers, some additional practical exercises were conducted. In the BCs' focus group discussions, we asked participants to list the things they liked and disliked about the transition to the new role and about being a BC. We subsequently asked them to rank the top three things they liked best. In the same way, we asked them to rank their dislikes (Fig 1).

In another exercise, mothers who recently had a baby, were asked to draw a flower telling us about their experience during the birth and the first few months with the baby at home. They drew a petal for each person who was important in delivering and looking after the baby before and after the birth, varying the size of each petal depending on how important each person had been (Fig 2).

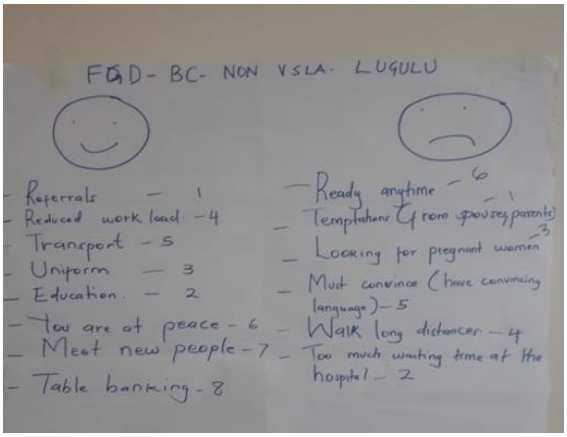

Fig 1: Ranked likes and dislikes of BCs from a FGD

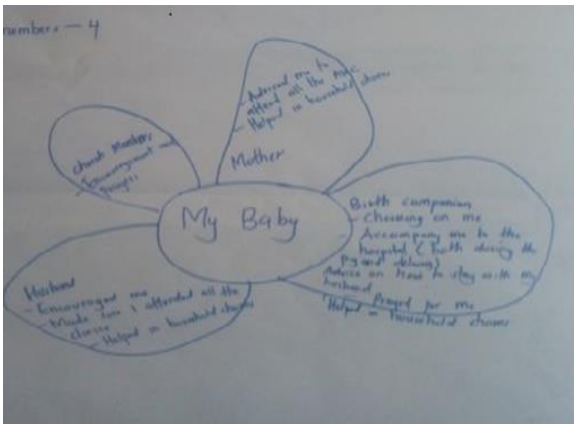

Fig: 2 Ranked levels of support received by a mother during the birth of her baby

The research collected data from 176 participants: 152 practicing birth companions, 12 health workers and 12 mothers in the six sub-counties mentioned in page 6. They participated in the following FGDs or KIIs:

- 6 FGDs with BCs who had were part of VSLAs. (One group per sub-county).
- 6 FGDs with BCs who were not part of VSLAs. (One group per sub-county).
- 6 KIIs with frontline health workers in facilities where BCs are active. (One per sub-county).
- 6 KIIs with health workers who act as BC supervisors. (One per sub-county).
- 6 KIIs with mothers who delivered at a health facility with the help of a BC in the last six months. (One per sub-county).
- 6 KIIs with mothers who delivered at home in the last six months. (One per sub-county).

The data obtained was subsequently coded using a basic structure and focusing on 6 main axis:

- Transition from TBA to BC
- Attitudes to the new practice
- Relationships and Community
- Money and Time
- Potential drivers for returning to TBA practice

3. Limitations to the study

This research, intended as a qualitative study, concentrates exclusively on the lived experiences and subjective perceptions of the people interviewed. Fifty percent of all trained Birth Companions who were trained by MANI participated in the study, together with a smaller number of health workers and mothers. Efforts were made to randomly select participants at the research study sites but this was challenging. Identifying mothers who had given birth at home was particularly difficult. All those identified stated that they had wished to deliver at the hospital but were unable to do so for a variety of reasons. It is likely, however, that these responses were influenced by participants' knowledge that the project actively supports institutional delivery. As a result of this response bias, the conclusions drawn in this report regarding the motivations of mothers who deliver at home are based mostly on BCs' perceptions of what motivates women.

During the project's implementation period there was a six month health care workers' strike. This strike significantly affected the targeted communities. It is difficult to tell if the experiences of our respondents would have been any different under normal implementing conditions.

Finally, we should note that at the time of the research, the project was potentially drawing to an end (a 12 month extension was eventually granted). This uncertainty did not emerge in the transcripts of our interviews even though some respondents who were aware of it (formal service providers). This, and expectations regarding the future of this project, may have influenced their inputs.

4. Findings

4.1 Transition from TBA to BC

4.1.1 Birth Companions' transition experiences: the positive aspects

The vast majority of the BCs in the research, when talking about the transition from TBA to BCs, reported they were satisfied and grateful. The primary reason for their appreciation was the training which they found very valuable. Eleven out of the twelve FGDs said that the training was well delivered. A few of the BCs said they would have preferred it to have been given at a slower pace, and a tiny minority would have preferred shorter training sessions. Largely, however, the trainings were extremely well received and systematically quoted as important and valuable. Furthermore, in the ranking exercise, (see Table 1 in page 9), increased knowledge was among the most liked aspects of the project.

The BCs appreciation for the knowledge acquired through the training and the opportunity to share this newly acquired knowledge was also widely mentioned. This primarily meant recognition for the BCs which resulted in many being called upon to address the community at public gatherings and being asked for advice on health matters. Some BCs mentioned that this increased their self-esteem and in several cases they reported that being seen as 'a learned person' has led to improved relationships, including those within the household, especially with their husbands.

Besides the general appreciation linked to the knowledge they received, BCs also expressed their appreciation for the materials given by the project. The T-shirt in particular was mentioned for helping BCs be easily recognisable in the communities and making their role official. A smaller number of BCs, however, commented that, while the materials were appreciated, they were insufficient and should be complemented by other products which are essential for them to fulfil their BC activities safely. Torches and umbrellas and bags were among the items identified by most the BCs as necessary for their role.

Access to VSLAs was also described as a positive output of the project. As mentioned before, MANI managed to offer access to this initiative for some BCs, as a way of accessing loans (from the group savings) and, in some way, replace the loss of income resulting by the transition of TBAs to BCs. BCs who have been included in VSLAs received 3 days of training on the VSLA model and a further 2 days training on how to start income generating activities. Then, they received support to meet as a group on a regular basis. This training was also valued by the BCs. A pattern that emerged throughout the research was that the groups that joined VSLAs had a higher level of appreciation of the project than those who did not. For example, BCs in VSLAs were twice as likely to express their appreciation for the materials received than BCs that were not part of VSLAs.

A key strategy of the project to increase deliveries at the health facility was the provision of transport vouchers. These were intended to be used by mothers to go to hospital for the delivery, and for the BCs that accompanied them. The project operates in rural areas with poor road connectivity and among communities that struggle to afford the transport costs necessary to reach the health facility not only for the delivery but also for antenatal and postnatal sessions. It is not surprising therefore, that the project felt it necessary to incentivise mothers in this way since the cost of transport was often mentioned as prohibitive. Additionally, BCs were also provided with a travel and lunch allowance for attending training sessions on a monthly basis. (Most of the BCs refer to this allowance as salary).

4.1.2 Birth Companions transition experiences: the negative aspects

The most commonly described experiences of transitioning from being a TBA to a BC were loss of income; not having appropriate equipment (umbrella, raincoat, torch, waterproof bag) and having to spend long hours taking mothers to health facility and waiting for the mother to give birth, sometimes not even being

allowed to be present when the baby is born. The majority of the dislikes expressed by BCs relate to direct loss of income or opportunity costs associated with their new role, for example having to spend significant amounts of time at hospital. It seems that this was further compounded when the newly trained BCs were not allowed to be present for the delivery which, many described as being the highlight of their work as TBAs.

In a few cases BCs expressed concern about transporting women in labour to hospital. This would not have been necessary if they were delivering with a TBA in the community. Concerns included drivers coming late or not at all; inability to access transport in a timely fashion was also one of the common reasons for mothers giving birth at home. Other BCs were concerned about safety, mainly due to poor road conditions and in very rare cases, labouring mothers did fall off the motorbike on their way to the health facility. Transport complaints also touched on the level of funding being insufficient and drivers refusing to come to the most remote areas or demanding additional payment. There were also some frustrations about the way vouchers were provided by the project. Some of these challenges were less about the BCs actual experience of transitioning from being a TBA and were more linked to implementation of the project. These difficulties were addressed over the life of the project.

A summary of BCs experiences of transitioning, in terms of what they liked/disliked is shown in Table 1 below. Overall, it is encouraging that the most commonly listed 'dislike' focuses on transport. This is something that is dependent on project implementation and can be improved as project experience increases. It would have been more worrying if lack of salary had been the most commonly cited as this would indicated a potentially significant attrition rate of BCs returning to TBA work.

Table 1: BC's Likes and Dislikes of the new practice

FGD Ref	VSLA	Like 1	Like 2	Like 3	Dislike
FGD1	No	Increased knowledge	Ability to teach others	Preventing deaths	Convincing mothers to start ANC
FGD2	Yes	Referring to clinic	Preventing deaths	Ability to teach others	No salary (no income)
FGD3	No	Referring to clinic	Following up with mothers	Hygiene and cleanliness	Transport problems
FGD4	Yes	Recognition	Increased knowledge	Respect	Strike
FGD5	Yes	Increased knowledge	Referring to clinic	Recognition	No salary (no income)
FGD6	No	Prevent deaths	Transport	Recognition	Working long hours
FGD7	Yes	Referring to clinic	Increased knowledge	Referring to ANC	Lack of sleep
FGD8	No	Referring to clinic	Prevent deaths	Recognition	Lack of raincoat, umbrella, spotlight, bag, gloves
FGD9	Yes	Identification of clients from a distance	Referring to clinic	Ability to teach others	Transport problems
FGD10	No	Referring to clinic	Increased knowledge	Recognition	Temptations to go back to TBA (lack of income)
FGD11	No	Prevent deaths	Increased knowledge	Hygiene and cleanliness	Transport problems
FGD12	Yes	Increased knowledge	Giving monthly reports	Attending meetings	Transport problems

4.1.3 Reasons for the transition and expectations for their new role

More than half of the BC FGDs agreed that lack of income was not a factor against deciding to make the transition to BCs. This applied to those participating in VSLAs and those who were not participating. Instead, the key reason for participants to transition into BC work was reducing mothers' and babies' deaths by encouraging mothers to go to facilities where they receive skilled care. It is deeply satisfying that throughout the focus groups and often in full consensus, BCs expressed the belief that since the new practice took root, maternal and newborn's deaths had decreased. The same belief was expressed unanimously by all health workers interviewed. Another frequently described reason for BCs to make the transition from TBAs, was the risk associated with engaging in a banned practice. TBAs described how they feared being arrested and so continuing to work with pregnant women but legally, made becoming a BC extremely inviting.

> *"I came and realized that it was risky … [] when someone dies on your hands, you know again that is a police case, so that is what made me to give in"*. BC

The BCs' choices in the ranking exercise, also reinforces this finding. "Referring mothers to hospital" was most frequently mentioned as a top reason to make the transition to the new practice in a ranking exercise, with five of the groups putting this in first position and a further two in second place.

The majority of BCs primarily cited saving maternal and newborn deaths as the key reason for changing their practice. But there were subtle differences in responses from the BCs in VSLAs and those not in VSLAs. For example, those not in VLSAs were more anxious about the risk of arrest by the police when working as a TBA. This could indicate that BCs who lack the motivation of a VSLA, might have focused more on the safety and have retained from the trainings a message more centred on fear. In seven of the 12 focus groups, BCs mentioned the risk of being arrested for practicing births at home.

> *"When I got the call that they wanted TBAs, my thoughts went far because I thought are coming to arrest us"*. BC.

As noted earlier, many BCs also appreciated the training they received and, with it, the opportunity to spread knowledge.

BCs also spoke about their expectations. All of our participants, members of VSLAs or not, admitted that they had dreamt that the project would be a new source of income and that their expectations were not met. Several BCs had imagined the project would lead to permanent employment or a regular income, especially as it replaces a previous economic activity. However, they all confirmed that the project never made such promises.

We also compared the opinions of front line health workers with those that act as BCs' supervisors and identified a pattern in their opinions regarding BCs' motivation and incentives. Notwithstanding the small sample size, (only 6 BC's supervisors), the majority of them seemed to interpret BCs' motivations as centred on incentives (transport and lunch allowances). In general, they appeared to have a lower opinion of the value of the service offered by the BCs than that of the front line health workers. This was an unexpected finding but a recommendation to address this issue is made in this report (page 21). BCs' supervisors also more frequently expressed the opinion that not all mothers need a BC and that perhaps this is more appropriate for poorer or less educated mothers. The vast majority of front line health workers however, expressed the opinion that all mothers should have a BC. They also believed the VSLAs provided a great incentive to them and highlighted that the training they received and the recognition they now enjoy in the community, would be enough motivation to deter them from reverting to TBA practice.

The new practice seems to be taking over among the community and the BCs report that the importance to deliver at a health facility has been widely understood. Systematically, both the BCs and health workers interviewed, expressed their belief that maternal deaths have decreased as a result of the project. It is also

widely noted that the BCs' role extends beyond simply accompanying women to the hospital for the delivery. Their role in encouraging mothers to attend antenatal and postnatal clinics, to follow up the newborns' vaccinations, and their advice on nutrition is also credited by front health workers as significantly contributing to general health improvements.

4.2 Attitudes to new practice

4.2.1 BCs' attitudes

BCs believed that as a result of their new role, mothers are more frequently attending antenatal care sessions and that they are providing better nutrition for their babies, but they recognise that their advice is not universally followed. The participants in two focus groups also mentioned that mothers have become more proactive in seeking medical advice and help when they realise there is a problem.

Among the BCs we also saw a great deal of appreciation for the improved hygiene that comes with the new practice. Through the research, we learned how TBA practice caused disruption to family life as mothers come to the TBA's house in labour and remain there until they have delivered. Above all, BCs clearly expressed their gratitude for no longer having to clean up. They also mentioned the social stigma of living in a house perceived as dirty by the community. The unhygienic TBA practice, involved attending the birth without gloves or other personal protective equipment. This was mentioned frequently by the BCs under the risks associated with this old practice.

On the matter of hygiene there were no substantive differences between the BC groups benefitting from VSLAs and those who didn't. This is interesting if we consider the observation previously made on the messaging of fear being more prevalent among the BCs that have not benefitted from the VSLAs. Based on this, we would have expected improved hygiene to be favoured by those fearing causing deaths or spreading disease, but instead, the appreciation for improved hygiene appears to be similar in both groups. This reinforces the notion that both groups were equally exposed to a fear-centred message but that this only became an anchor for those who did not experienced something more positive out of the project.

i. Health workers' attitudes

> "*In the past, when a baby was born, we would just leave it that way, but now we follow up, until the baby reaches six months…we follow up that he has got immunization…*" BC

Front line health workers expressed unanimously their appreciation for the work of the BCs. Rather than just being seen as contributing to increasing institutional deliveries, health workers described how BCs are identifying early signs of complications during pregnancy and directing mothers to seek prompt medical advice. They also ensure that births take place in health facilities and then, encourage women to take their babies for immunisation. In this vein, over half of front line health workers stated their belief that their workload had eased because of the reduced number of complications undetected until birth and that fewer caesareans were now needed due to the early intervention of BCs.

However, as mentioned before, BCs supervisors tended to express that the BCs are performing their role mainly because of the incentives received from the project.

4.2.3 Mothers' attitudes

A level of disappointment was expressed by the women's KIIs, as well as by BCs themselves, that services not related to delivery which were previously offered by TBAs, such as massages, are no longer allowed. They also regretted that dispensation of traditional medicine, and occasionally abortions (which are illegal)

are also not allowed. The project stopped massages and dispensation of traditional medicine to optimise the best aspects of the TBAs role (support for women) and prevent those that could be harmful.

While mothers expressed that they missed these services and considered them beneficial, many of the BCs believed that massages still have a role and a few believed the traditional drugs should have a place. It is important to identify which of these might potentially be taken forward to provide additional support to women and increase the value of BCs' role. It seems likely that enabling BCs to provide non-invasive massages might make women's experience of labour and delivery more positive. However, this would have to be explored further. It may also reflect BCs regret for loss of income generated in this way, and some women describing a broader sense of rejection by BCs who not only referred them to hospital but also refused to provide comfort through massages.

b. Relationships and Community

4.3.1 New status experienced by BCs

A central dimension of our analysis revolves around the newly found respect that BCs enjoy in their communities. This was anticipated and, in line with our expectations, we confirm that the BCs have found respect and recognition from the community as a result of the transition. Every FGD reported, that the TBAs had gained new respect in the community when they transitioned to BCs. Only in a handful of cases we heard BCs say that the level of respect they enjoy in the community had not changed and nobody said they believed they enjoyed a better status when they were practicing TBAs. We believe that this new status in the community can be one of the main reasons for BCs to maintain the new practice and not revert to TBA work after the end of the project. In two cases we heard the downside of this new recognition: BCs are believed to be employed and they face expectations from other community members, such as being asked for loans and contributions.

> *"Respect has grown, there is respect everywhere including the villages and the hospitals. My husband even says that this job is better than in the past where we used to do fake things. He even suggests that if we buy a cow and chicken we name them "birth companions"*. BC

BCs reported that the new respect and recognition had resulted in an increase in their self-esteem. They also felt pride at no longer being involved in a practice that can result in deaths.

As mentioned above, in a few cases, particularly among BCs who were not part of VSLAs, they reported missing the relationship previously enjoyed with mothers and the role in bringing a new life into the world.

The increased respect from the community that BCs experienced as a direct consequence of their new role covered several categories. Firstly, BCs referred to the explicit recognition by the community of their newly acquired knowledge and skills. This was paired with pride at being asked to address public gatherings to spread knowledge and raise awareness on the importance of delivering at the hospital, the ante and post-natal clinics, the vaccinations, etc.

Secondly, the recognition of health workers was highly important to BCs. For many the improved relationships with health workers, both at community level, with community health workers, and at the health centre was a source of great gratification. There were however, some infrequent mentions of friction between the BCs and community health workers or hospital staff.

In line with this finding, we noted that a few BCs felt frustrated for their exclusion from the delivery room, missing their involvement in the actual process of giving birth. This is particularly interesting in light of one of the best known benefits of having a BC: providing companionship to mothers during labour. It is therefore hard to explain why some health centres would prevent the BC from being actually present during the birth. Additionally, several BCs explained how they became TBAs based on a vocation or calling. They believe they possess a special talent or purpose to provide comfort to mothers in pain.

During the flower exercise (page 6), three quarters of the mothers drew a larger petal for the BC than they had for the medical staff. Additionally, two thirds of frontline workers mentioned the importance of a warm and comforting presence in the delivery room. Furthermore, both health workers and BCs reported an additional function performed by the BC: cultural mediator and occasionally translator. Whereas these soft skills may not appear as important to supervisors, they are undeniably important for mothers as we will see below in the section concerning drivers to TBA practice.

Interestingly, some also reported tensions with other TBAs who have not converted to BC practice and fear the competition of the BCs who 'steal' their clients. Although only a small minority reported this, it is nevertheless interesting to see that these tensions exist.

Finally, we were surprised to hear that three quarters of the BCs of our FGDs, had experienced improved relationships and increased levels of respect from their husbands. This was linked occasionally to the training allowances received, but more often to the increased knowledge and respect gained in the community.

4.3.2 Improved relationships between BCs and health workers

BC's supervisors also agreed that BCs now enjoy greater recognition in their communities due to their new official role and front line health workers, reported having improved, and good, relationships with BCs and valuing their work. They observed how the presence of a BC during the delivery eases the workload of the overworked professionals and expressed their gratitude for this.

> *"What I can add is the relationships between health care workers and the BCs have really improved because [] we are all working towards the same goal, and want to achieve the same: the improvement of maternal and neonatal deaths."* Front line health worker.

4.4 Money and Time

The primary focus for our research was to better understand the extent to which the new practice would be maintained after the life of the project. In order to do this, we needed to examine in detail if the newly trained BCs would have the means, motivations and the opportunity to continue their new way of practicing. As TBAs, these women earned an income whilst their role as a BC is voluntary. To a large extent the sustainability of the intervention rests on the assumption that BCs will continue to accompany or refer women to health centres and decline the opportunity to earn by assisting them at home.

As mentioned above, half of the participating BCs groups were from among those who had been included in VSLAs. This enabled us to compare the attitudes between those who were given an alternative strategy for generating an income and those who had not.

> *"She [the mother] goes back home and everything will be over. She will only say 'thank you mum', but not thank you with something at hand, but thank you of the mouth."* BC.

All the FGDs reflected that the new practice had brought a reduction in income. In addition, TBAs also used to enjoy income generated from massaging mothers and from dispensing traditional remedies. Only a handful of BCs reported their income had remained the same, although some admitted that, previously, mothers would occasionally walk away without paying to the TBA after giving birth. They also mentioned that some women were so poorly prepared for the new arrival, that the TBA felt obliged to give the mother something, such as a shawl or a piece of fabric for the mother to carry the new baby home. It is interesting to notice that reference to mothers not paying for the TBA service typically referred to the

birth, but not the massages during pregnancy. This is possibly because the massage can be delayed until a mother has some disposable income whilst the birth cannot be scheduled.

As briefly described earlier, although most BCs were satisfied with their new way of working, but all reported that they had been disappointed in the income generating aspect (or lack of it). In about a quarter of the cases, the new BCs had expectations of becoming state employees within the health sector. At the same time, due to the uniform provided by the project, some participants experienced demands for support from the community as some of its members thought that they were employed. When in fact, BCs have to leave their households and animals unattended to accompany a mother to the health centre without receiving any money from the time and effort they are putting in the new role. Seven out of twelve groups, reported that their expectations that the new practice would at least save them some time, were equally disappointed. The long waiting time at the hospital was in fact mentioned by many, and several observed that previously, when women would deliver at home, the TBA was at the very least, able to continue her household chores or keep an eye on the animals grazing at the same time.

> "*Based on all the knowledge, actually I have been able to change my life, I have left from doing house business now I have built a canteen, from this BC work, and now I have a stock. […] I am able to take my kid to school*." BC.

In eight out of 12 FGDs, the BCs also mentioned with gratitude the income they receive from the project in the form of transport and training allowances. Those groups expressing gratitude for the allowances were primarily groups not in VSLAs. It should be noted that these allowances and travel reimbursement will no longer be available when the project ends. However, the BCs did not appear to be aware of this. We should nevertheless reflect on the temporary nature of this income and the risk to sustainability once the project ends.

4.4.1 VSLAs

MANI project trained and established 7 VSLA groups in Bungoma County with existing BCs in August 2016. They were assessed in November 2017 after one year of implementation and were ready for the next phase or cycle. The savings plus interest sharing–out and the graduation exercises were carried out in December 2017. The groups' performance was generally impressive as the average return on savings was 55% and total money shared-out across the board was Kes 532,040.00. The VSLA was among the most praised initiatives by the project alongside the training received, even by those BCs who were not included in this activity. Three FGDs of BCs not included in VSLAs, directly asked for a VSLA to be created for them and one of the groups that was part of a VSLA actually said unanimously that this was the most valuable part of the project.

> "Through VSLA, I started a project of horticulture and poultry keeping". BC in VSLA

> "*If we compare what we earned before with now, -all has been covered through the VSLA because instead of the salary we used to admire, we put here shares and we borrow money, the school fees for the grandchild you invest your shares and you borrow money so we see other things…So they helped us a lot because instead of being employed you create your own employment*." BC in VSLA

All the VSLA groups were reported to be fully functioning and all participants had had an opportunity to borrow and had initiated an income generating activity. Almost all of the groups reported some initial problems primarily caused by misunderstanding of interest rates, but this was later resolved. This could be due to the low levels of literacy among these groups that required longer sessions of financial literacy training adapted to their needs, but it could have also been that since VSLAs were not a central to the project, they did not receive sufficient technical support.

Systematically and often unanimously members of VSLAs explained the initiative had been a useful medium to diversify their sources of income, as expected. Some mentioned

enjoying the social aspect of it as well. Finally, others also mentioned finding the training valuable in itself; even if it did not lead to the creation of a group.

The BC groups not involved in VSLAs focused their gratitude for the project on preventing deaths and risks, rather than fear. This thinking is also reflected in their dislikes. These were more concentrated on two topics: the voluntary nature of the work and the problems with the transport arrangements. It is interesting to see that the voluntary nature of the BC work was not brought up as dislike by those not participating in VSLAs.

This could mean that the BCs not involved in VSLAs have focused on the loss of income whilst those who are involved in VSLA are now much more conscious of the opportunity cost of a time-consuming voluntary activity. This raises the possibility of another threat to the continuation of the activities once the project ends. Two thirds of BCs now formed in VSLAs express their relief at not having to deliver mothers at home anymore by ranking this aspect of the project among their top three favourites. All but one of those groups pointed to the lack of income from the project or problems with the transport as their top dislike. Some of the explanations provided point to the fact that they now may have to neglect their more profitable income generating activities in order to accompany mothers, a non-remunerated activity. Once the project stops providing those small incentives and reimbursements for taking part in the activities, there is a possibility that BCs may face the dilemma of abandoning their new business to accompany mothers to the health centres particularly given their frustrations with the transport system, which will no longer be subsidised by the project.

4.5 Potential drivers for going back to TBA practice

> "*Because you know the TBA when you go to her, she consoles you, she boils warm water for you, she takes the water to the bathroom for you, she washes you, she makes tea for you, she soothes you very well, not like the hospital where, when you go they harass you, they just leave you there*". A BC reporting on mothers' experience of the health centre

Half of the BC groups who participated in our research stated that they believed there still is a role for TBAs even though they were widely complimentary about the project's work. Understandably they were reluctant to say this openly, but some quoted other traditional services offered, massage and dispensation of traditional drugs as an example of the role TBAs can still play. BCs reported that many mothers still prefer to be attended to by a friendly local woman. This preference is also acknowledged by health workers. Others raised the issue of emergencies when there is not enough time to reach the hospital.

The research also enabled us to uncover some aspects of TBA practice that are still widely missed both by the BCs and, reportedly, mothers. Undeniably, for some TBAs, the practice is a service delivered in exchange for payment, either in cash or in kind. However, for many of them, the practice is also a source of gratification and fulfilment. Several mentioned that being present whilst a new life is born is a great privilege whilst others refer to their involvement as a calling and a unique talent they have received, sometime passed down from generations. The ability to comfort and support a young woman at her most vulnerable moment and to provide reassurance and encouragement is something that many of the TBAs miss when they are not allowed to be present in the delivery room.

> "*BCs really know how to encourage these mothers. And they have time, unlike us. I am attending to her and am having another patient*" Front line health worker.

The relationship and connection between mothers and TBAs is missed not only by the new BCs but also by the mothers. We reported that the soothing traditional massage is missed by mothers and some mothers feel rejected by the BCs when they refuse to help them and direct them to the health facility instead. These feelings were common among all the groups and there was no noticeable distinction between those involved in VSLAs and those that were not. There appears to be a genuine motivation for this practice beyond gaining income. Some described with a great deal of emotion their previous TBA role and how they now suffer

from the restrictions in place by most health centres that do not allow them to accompany the mothers in the delivery room. Interestingly when they are allowed to be present, frontline health workers seem to find them very helpful not simply for easing their workload and providing comfort to the patient but particularly when persuasion is required to convince a mother to do something that is not according to traditional cultural norms. This role of cultural mediation and the value it has for the health services appears to have been underestimated and might be a driver for women to refuse the new services.

Although there might be valid reasons to ban BCs from delivery rooms, we should also acknowledge this ban means women end up delivering on their own aided only by a health worker they do not know, sometimes male, and occasionally speaking a language the patient is not comfortable with. The fact that all this happens while on the other side of the door is a woman, often dedicated, known to the mother and capable to offer a word of comfort, appears to contrast with good practice and WHO recommendations[1].

With regards to potential drivers from mothers to revert to TBA practice, we can mention that all mothers interviewed, except one who had a personal attachment to a TBA, said they had planned to give birth in hospital. This is understandable given the mandate of our research. Those who gave birth at home, were not able to reach the hospital on time whilst in other cases, the health workers' strike was the reason for delivering at home. However, BCs reported that not all mothers are happy to go to the health facility, for a variety of reasons among them, distance to the health facility, fear of charges and treatment by hospital staff and that those mothers, deliberately wait too long before seeking the help of a BCs as a way to manipulate them into helping them deliver at home.

However and taking into consideration all the opinions expressed above, the study identified 3 main issues that could act as drivers for the communities (BCs and mothers) to revert to TBA practice.

4.5.1 Difficulties in accessing transport to health facility

The provision of transport vouchers was very well received and has been pivotal for mothers to decide delivering at the hospital, in spite of some complaints. However, it is not clear if all women or their families will be able to spend their own money to travel to the hospital after the project ends. The findings tell us that women and increasingly men have been persuaded of the importance of giving birth in a health facility and the need to pay for transport for the birth, if they are able to do so. It is less so, for the ante and post-natal appointments including babies' vaccinations. However, it is hard to imagine that some of the poorer women/families would be able to pay for a motorbike ride to the health centre once the project comes to an end.

It is even more questionable that BCs would pay themselves for their transport costs in order to continue accompanying mothers and that if they fail to do so, it would not put in jeopardy the sustainability of the intervention. When we consider the perceived lack of awareness about the impending end of the project, we need to question what would happen in the scenario where a mother in labour wants to go to the health facility with the BC but neither of them can afford the transport. In this scenario, it is not entirely unconceivable that the BC could be persuaded revert to TBA practice.

4.5.2 Loss of income

Whilst all the BCs noticed their income has reduced as result of their conversion from TBA to BC, it is difficult to determine the long term impact that this will have on their willingness to continue with the new practice. As mentioned before, the transport and training allowances have been regarded as 'income' by the BCs. Looking into the future, we can see that BCs not involved in VSLAs are more likely to be disappointed by the end of these allowances and could be tempted to return to their TBA practice. We believe though, that this outcome is unlikely since the MANI project has been quite successful at advocating for hospital

[1] https://www.mhtf.org/2017/10/12/why-doesnt-every-woman-deliver-with-a-birth-companion/

deliveries and these women have been on the front line of such efforts. A return to TBA practice would entail a loss of face for these women and compromising their newly acquired and much appreciated status.

However, we should take a more granular view of the loss of income incurred by TBAs. Only a part of the income they have lost relates to supporting women during births. Incidentally this is the part which entails cleaning after the birth and causes disruption in the family. The other source of income for TBAs was the provision of massages and traditional medicine. Many in our research mentioned missing this aspect of the role, as well as the income that it generated. To a large extent massages and traditional medicines represent the bulk of the "technical" expertise of a TBA, whilst assistance during the birth largely revolves around providing encouragement, food, drink and cleaning. This explains why they should miss this so much. The ban on both these activities by the project, whilst understandable, has caused significant disappointment among the BCs who see not only their income reduce as a result, but also a diminished acknowledgment of their competence. The BCs that are not involved in VSLAs appear to be more at risk of reverting to old practices, but this same group seems to have better internalised the fear message, so we can conclude that the ban related to the provision of massages (and traditional medicine) may not in itself be a sufficient driver for BCs to revert to TBA practice.

The project has been very successful in persuading BCs not to provide massages, but it does not appear to have been equally successful at reducing the demand from mothers.

4.5.3 Attitudes of health professionals towards mothers

One area that still appears to be highly problematic, concerns the perceptions of the attitudes and behaviours of health professionals towards mothers. According to the BCs, the fear of abuse emerged as a main factor driving mothers away from health facilities. In all FGD, BCs, unanimously, reported that mothers' perceptions that an unwelcoming, humiliating and often abusive reception awaits them at the health centres.

Whether real or perceived, they represent a major deterrent in using health facilities. Furthermore, if indeed practiced, ageism, harassment and hitting (also mentioned consistently) have no place among the caring profession. Some mothers and BCs refer to these as "disrespect" by health professionals, but the wording and examples given by the BCs, seem to point more towards abuse.

Whilst some health professionals have brushed this aside as a thing of the past, the vast majority still recognise that the main appeal of BCs/TBAs is the compassionate care they provide. This can be interpreted as a veiled admission by health professionals that their bedside manners leave a lot to be desired. Whether these practices continue to take place or women's fears in this respect are a heritage from the past, this is irrelevant to a large extent, as these fears, real or not, will be sufficient to deter mothers from seeking medical help.

Healthcare professionals also acknowledged this perception, but did not accept that this was a practice, preferring to say it was a thing of the past. However, rather frequently, health workers noted that mothers preferred the warm and sympathetic behaviour of TBAs over that of medical professionals. Repeatedly, they also acknowledged the lack of resources and having to see several patients at the same time. Reading between the lines, however, it is hard not to give any credence to the claims. One supervisor, for example, mentioned how working in a teaching hospital means that there are many young doctors who frequently subject women to unnecessary vaginal examinations in order to practice their skills. Unsurprisingly, this is seen as degrading by the women.

Probing further on these claims, we saw many BCs reported ageism among health professionals. According to them, teenage or mothers over 40 years of age fear mockery and derision and this deters them from attending the facility. This is not acknowledged by the health professionals, but they did say that teenage mothers prefer not to attend the health facility and neither do more experienced mothers.

Interestingly, everyone participating in our research appeared to suggest that mothers prefer the way in which TBAs provide care, but frequently this was portrayed by health workers, as manipulation to extract more money from the mother.

The transcripts of the BCs group discussions revealed the fears of labouring mothers. Two verbs were systematically but not interchangeably used to describe their fears: to harass and to hit. Their recurrent and appropriate use clearly indicates that both behaviours are believed to be real and present. We should note, however, that only one of the mothers interviewed reported being harassed and 'chased' out of the hospital for arriving too soon before the birth. This mother actually gave birth on her way back home, at an intersection.

A third practice feared by women, according to the BCs, relates to the enforcing of a birthing position (lying on the back) that mothers regard as uncomfortable and culturally inappropriate. The BCs reported that women in the locality traditionally give birth on their knees which they regard as the culturally appropriate position. They also believe that lying on their back will make labour last longer and be more painful. It is easy to understand why insistence on this position would cause grievance. Interestingly, even some frontline health workers mentioned their appreciation for the BCs who use their influence and emotional connection with mothers to persuade them to deliver in a position other than what feels natural to them. Whilst there might be valid medical or practical reasons for asking women to lie on their beds, if we want to see increased attendance at the health centres then flexibility is needed in allowing patients to choose what feels most comfortable to them and show greater respect for their cultural beliefs.

According to BCs, two further health centre practices were also a deterrent for labouring women: the prevalence of male staff and HIV testing. The latter one was acknowledged by both BCs and health professionals. Fear of finding out one's status was prominent but for a small minority the fear of exposure was also a factor. The fear of being attended by a male doctor or nurse was reported in several occasions by BCs as being behind the reason why mothers would delay seeking help and in extreme cases already at the facility, refuse to push. Whilst health professionals appeared to downplay this fear and in some cases stated that women actually prefer to be attended to by male staff, the BCs adamant that the presence of male staff was in fact a cultural barrier.

Patients attending health facilities should be confident that their cultural beliefs will be respected. On a few occasions, we heard how ignoring traditional norms on the handling of the placenta following the birth was a cause of grievance to some mothers, but far more often, being forced to assume a particular position for the birth was a major issue for mothers, as also reported by the BCs. This was also echoed by the health professionals themselves.

Finally we should mention that some of the BCs participating in our study also believed that the MANI project had in fact contributed to improving attitudes and behaviours of the health professionals. An even larger number of them believed mothers accompanied by BCs receive preferential treatment on arrival at the health facility due to the project and the friendly relationship between the BCs and the health staff. None of the health staff mentioned providing more favourable treatment to mothers accompanied by a BC but some of the frontline workers implicitly admitted that due to overwork they were not able to dedicate too much attention to each patient and that those accompanied by a BC were bound to have a better experience.

5 Conclusions and Recommendations

The vast majority of the participants in the research were satisfied with the transition and grateful for the support they received while going from TBAs to BCs. The primary reason for their appreciation was the training which they found very valuable. This training translated into acquisition of knowledge for BCs and recognition for them. They found new recognition in the community and even in their own households and this has increased the BC's self-esteem.

The findings also point out that the main reasons for TBAs wanting to take part in the transition to BCs, are twofold: prevent deaths of mother and babies by referring them to health facilities where they will receive skilled care and fear of being involved in a banned activity.

From the evidence reviewed, it appears as if the MANI project has been successful at facilitating the transition of TBAs into BCs. None of them envisaged going back to their old practice, partially because there is better understanding of the risks for mothers and babies, for themselves and in general for the community. But also because of the recognition they receive in their new role. A return to TBA practice would entail a loss of face for these women and compromising their newly acquired and much appreciated status.

However, our research with BCs, mainly, highlighted three main factors that could drive TBA practice in the communities in order of priority:

1. Real or perceived negative attitudes of health professionals towards mothers
2. Difficulties in accessing transport to health facility
3. Loss of income: BCs missing the financial incentives that TBA practice used to generate

There are some recommendations that emerge from our study that raise a few options to help consolidate the gains of this project:

1. Explore the opportunity to expand the VSLA groups so all BCs can have access to one. As noted throughout the report, VSLAs have provided a strong motivation for BCs and have unanimously been reported as a successful addition to the model.

2. Develop a strong exit strategy with regards to transport vouchers that will continue allowing mothers (and BCs) go to health facilities.

3. Although the hospital service is free, BCs acknowledged that the fear of charges was a main barrier for mothers. It is recommended that the project continues working to widespread the knowledge that the maternal services at the hospital are free.

4. Address the presence or perception of harassment by health professionals towards mothers, by raising awareness on patient's rights, complaint mechanisms and expected standards of care from the medical professionals. Explore ways to support professionals to adopt a kinder and more respectful behaviour to mothers.

5. Initiate dialogues with all hospital staff across the sub-county to promote better understanding of the role and motivations of the BCs in particular with their supervisors and reflecting on the following:

    a) Ensure consistent respectful treatment to BCs from health facilities staff. Some BCs reported low levels of respect for their role. This also transpired from health professionals. Not being respected by health professionals is of particular importance for those former TBAs who are truly passionate about their vocation.

b) Explore the reasons why some BCs are reportedly banned from accompanying mothers in the delivery room when mothers would have wanted to have them near. If it is found out that it is beneficial for the mother to have a BC in the labour room, then guidelines should be issued to allow BCs to sooth and comfort the patient, to accompany her while giving birth.

6. The MANI project has been extremely successful at utilising the network of BCs to propagate project's messages. The project should consider capitalising on this network to bring feedback from the community on what might put in jeopardy the new practices. Clearly, the BCs enjoy a good relationship with women in the community and have access to information that is valuable to the project.

7. Finally, this study wants to encourage further health and anthropological research to learn more about the findings. For example:

   a) Explore health risks for mother and child when traditional massages are provided by TBAs. If it is found that there are no health risks, consider reinstating traditional massages as this could bring benefit mothers and BCs.
   b) Research traditional birthing positions in the geographical area and its feasibility to be implemented in health clinics. At the moment the health facilities offer only one (lying on the back). While, there might be many valid reasons for this, standard practice should be rebalanced on the side of the patient's preference.
   c) Learn about traditions around the disposal of the placenta, the importance for mothers and feasibility of providing these options at health facilities, etc.