EXPLORING THE MOTIVATIONS OF BIRTH COMPANIONS

A QUALITATIVE ASSESSMENT

Maternal and New born Health Improvement Project

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31st January 2018

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Introduction

Kenya has still 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, particularly in rural areas. 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. In particular, MANI is strengthening health systems; increasing demand for services and funding innovative projects delivering local solutions to local problems.

The MANI project started in May 2015 by a Consortium led by Options, working in partnership with a number of organisations, such as, CARE (CARE International UK and CARE Kenya), MSI, Manion Daniels, IHPMR, AMREF Health Africa, Population Council and KPMG.

One of the MANI project's interventions focuses on training and reorienting Traditional Birth Attendants (TBA), to become Birth Companions (BCs). TBAs are women who help mothers in the village to give birth at home. This is a vocational job which they perform without having been trained, TBAs receive payment for their services either in cash or in kind. The BCs, trained by the project, do not conduct deliveries at home, but rather refer and accompany pregnant women to health facilities for antenatal visits and delivery. BCs also play an important role as advisors on nutrition and other matters related to pregnancy, delivery and postnatal care within their communities. Since the project started in 2015, MANI has trained 305 TBAs, across all 6 sub-counties of the Bungoma county to become BCs. All TBAs are now performing their new roles as BCs.

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 1980's, the WHO developed a curriculum used to equip TBA's with knowledge to support deliveries occurring at home. The worsening maternal and neonatal indicators prompted a change in the WHO policy in 2000 stopping the TBAs from conducting deliveries at home. In Kenya the Reproductive Health Policy of October 2007, affirmed this position, recommending a change in their roles. Despite the policy stopping the home deliveries by TBA's, they continued to deliver children at home. Indicators in Kenya continued to worsen, making the country off track to meet MDG 4 and 5 by 2015.

While it is widely acknowledged that re-oriented BCs can play an important role in accompanying and referring women to a health facility for a skilled care delivery, there is also a recognition that this new role may imply a loss of income (in kind or cash) for BCs. Cognisant of this loss of income, MANI set up an additional intervention, Village Savings and Loans Associations (VSLA) for some of the BCs, but not for all. MANI also provided BCs basic kit, including gumboots, a torch and a MANI Birth Companion shirt.

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. It is therefore vital for the sustainability of the initiative that we understand the different dynamics of motivations and incentives linked to the new practice.

The MANI project therefore, undertook a piece of research to understand the reasons that encourage BCs to continue practicing their new role, or if there are any incentives that could draw them back to their previous role as traditional birth attendants. This paper presents the findings from the research. Whilst the project has had monitoring and evaluation activities, this research aimed to better understand the motivations that might keep BCs practicing their new role, incentives for them to continue performing as BCs and to identify any factors that might draw them back to their previous role as TBAs.

Methodology

This is a small qualitative study focussing primarily on 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 from their previous role as TBA.
4. Explore any other unplanned change 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.

Two main techniques were used in this research for data collection: focus group discussions (FGD) and key informant interviews (KII).

In this research we conducted:

- 6 FGD with BC who have been also included in VSLAs. (One group per sub-county).
- 6 FGD with BC who are not part of VSLA. (One group per sub-county).
- 6 KII with frontline health workers in facilities where BCs refer mothers. (One per sub-county).
- 6 KII with health workers who act as BC supervisors. (One per sub-county).
- 6 KII with mothers who have delivered at a health facility with the help of a BC in the last six months. (One per sub-county).
- 6 KII with mothers who delivered at home in the last six months. (One per sub-county).

Additionally, during the FGDs and KIIs with mothers, we also conducted some practical exercises. In the BCs focus group discussions, we asked the group to list all the things they liked and disliked about being a BC and the transition to the new role. We subsequently asked them to rank the top three things they liked best. We also asked them to indicate the worse thing out of their list of dislikes. Similarly we asked mothers to draw a flower telling us about their experience of having their last baby and the first few months with the baby at home. They were instructed to draw a petal for each person that was important in delivering and looking after the baby before the birth and after varying the size of each petal depending on how important each person has been.

The data collection was conducted with the help of six local research assistants, all female as the BCs themselves. The interviews were conducted in Kiswahili and occasionally a local language (Lubukusu). The research assistants worked in teams of two, facilitated discussions and exercises. They were instructed to take notes on what has been said but also on body language and reactions to comments by the rest of the group. Subsequently the research assistants typed the entire transcripts in English including observation notes into purposely created templates for the data analysis.

In total our research collected data from 140 practicing birth companions, 12 health workers and 12 mothers in six sub-counties.

The data obtained was subsequently coded using a basic structure and focussing on the main axis of this research:

- Transition from TBA to BC
- Attitudes to the new practice
- Relationships and Community
- Money and Time
- Drivers for TBA practice
- VSLAs.

Limitations

This research, intended as a qualitative study with a narrow focus, concentrates exclusively on the lived experiences and subjective perceptions of the people interviewed. The primary subjects of this research were the Birth Companions (BCs), trained and supported by the project. Almost 50% of them participated in this study. The other respondents' views included in this study, (health workers and mothers), do not form a representative sample of the entire group they represent. Whilst all efforts were made to select participants at random, logistical considerations were also a factor. In particular, the team found it challenging to identify mothers who had given birth at home. All those who fell in this category, stated that they had wished to deliver at the hospital but were unable to do so for a variety of reasons. This is most likely due to the awareness that the project actively supports the referral to hospital policy.

All conclusions drawn in this report regarding the motivations of mothers who deliver at home are mostly based on what the BCs reported from their extensive contacts with mothers. A further limitation could be the impact of a six month strike of health care workers that affected the targeted communities during the operation of this project. 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 drawing to an end, but this did not emerge in the transcripts of our interviews. Our respondents may have had varying expectations regarding the future of this project and these expectations may have influenced their answers.

Findings

1. Transition from TBA to BC

The vast majority of the participants 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. 11 out of our 12 FGDs mentioned the training promptly, and this was agreed by all the participants. Overall they thought that the training was well delivered and, whilst a few of the BCs would have preferred the training to have a slower pace, a tiny minority would have preferred shorter training sessions. However, largely, the trainings were extremely well received and systematically quoted as important and valuable. Furthermore, in the ranking exercise, increased knowledge was among the most liked aspect of the project.

> *"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

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

Besides the general appreciation linked to the knowledge received, BCs also expressed their appreciation for the materials given by the project. The T-shirt in particular was mentioned systematically for helping BCs be easily recognisable in the communities and making their role official. However, those same materials were also a major reason of complaint. This was because, while, the BCs appreciated receiving materials to do their job and being recognised, they also felt that the materials given were insufficient and that they lacked other key inputs to fulfil their function safely. Torches, umbrella and gumboots were among the items identified by the majority of the BCs as necessary for their role.

As mentioned before, the VSLA intervention was offered to some of the BCs, as an option to generate income lost by the transition of TBA to BCs. Village Savings and Loan Associations (VSLA) 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. 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.

There is an interesting distinction between BCs involved in VSLAs and those who were not, when they talk about the materials (T-shirts and gum boots) distributed by the project. BCs in VSLAs were twice as likely to express their appreciation for the materials, than groups who were not part of VSLAs. However, they also expressed problems about the lack of other necessary materials. The groups not participating in VSLAs were more likely to express more disappointment and problems in relation to the materials given than appreciation. None of the BCs of either group mentioned using their own funds to pay for any of those materials. 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.

A key strategy of the project to increase deliveries at the health facility was the provision of transport vouchers for the mothers to go to hospital with the BCs. 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 ante and post-natal sessions. It's unsurprising 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 allowance for attending training sessions on a monthly basis.

> *"One time I fell (off the motorbike) with a patient because he [the driver] was drunk and it's only him that was given the tender to transport patients where I live."* A BC on issues related to transport.

However, among the complaints, there are issues pertaining to the safety of the transport provided for mothers in labour and also with the way vouchers were provided by the project. BCs reported a range of issues in this regard: drivers coming late or not at all, the journey not being safe and in some extreme cases, labouring mothers falling off the motorbike on their way to the health facility. Inability to access transport in a timely fashion was also one of the common reasons for mothers giving birth at home. 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 were also common.

When we examine the expectations TBAs had when transitioning into the new role, a clear pattern emerges. More than half of the groups mentioned that income was not a factor in deciding to make the transition to BCs. (In equal numbers those participating in VSLAs or those not participating). However, all of our participants, members of VSLAs or not, admitted that they had dreamt that the project would be a new source of income, especially as it replaces a previous economic activity, but they all said their expectations were not met. Several BCs had imagined the project would lead to permanent employment or a regular income, although they confirmed that the project never made such promises.

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	Prevent deaths	Convince mothers to start ANC
FGD2	Yes	Referring to clinic	Prevent deaths	Ability to teach others	No salary (low 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 (low 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, gumboot, 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 (go back to TBA)
FGD11	No	Prevent deaths	Increased knowledge	Hygiene and cleanliness	Transport problems
FGD12	Yes	Increased knowledge	Giving monthly reports	Attending meetings	Transport problems

As noted, many BCs mentioned appreciation for the training received and the ability to spread knowledge and save lives as a key factor in the transition. However when BCs were asked about their expectations, we found that disappointment at the level of training was more frequent than appreciation and disappointment was also mentioned because they did not receive certificates for this training.

Interestingly, those complaints come uniquely from those not participating in VSLAs which would suggest their desire to see the new activity leading to a recognised qualification or perhaps employment elsewhere through the training they received.

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

Among the reasons for BCs to make the transition from TBAs, was the risk of engaging in an illegal practice. However, in actual fact, the overwhelming reason for the participants to endorse the new practice was reducing mothers and babies' deaths. Throughout the focus groups and often in full consensus, BCs expressed the belief that since the new practice took root, maternal and newborn deaths had decreased. The same belief was expressed unanimously by all health workers interviewed. Many BCs also expressed a change in their self-esteem deriving from the pride of no longer being involved in a practice that can result in deaths. On various occasions, it also emerged that TBAs feared being arrested. 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 putting in in second place.

As mentioned above, the ability to prevent deaths by observing the new practice, was favoured primarily by groups not included in VSLAs. Improvements in hygiene followed a similar pattern. This might suggest that the 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. In several cases it was clear that the fear of being arrested by the police had been reinforced by the project, but this message appears to have been internalised more by BCs who are were participating in VSLAs.

> "*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

When we compare the opinions of front line health workers with those health workers who act as supervisors for the BCs, we also notice a clear pattern in their opinions regarding BS's motivation and incentives. Notwithstanding the limitations of a very little sample, we can see how the supervisors interpreted the BCs' motivations as centred on income. In general, they appeared to have a lower opinion of the value of the service offered by the BCs than those of front line health workers. They 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 although one interviewee stated that the main advantage of a BC is the transport voucher. The majority of the supervisors interviewed believed BCs to be motivated for the new practice by the incentives provided by the project. 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. In one case a health supervisor believed that the recognition BCs now enjoy would be sufficient to deter them from reverting to TBA practice.

The new practice has been undoubtedly accepted by 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 extend beyond the simply accompanying to the hospital for the delivery. Their role in encouraging mothers to attend ANC and follow up with vaccinations, and their advice on nutrition is also credited for general health improvements.

2. Attitudes to new practice

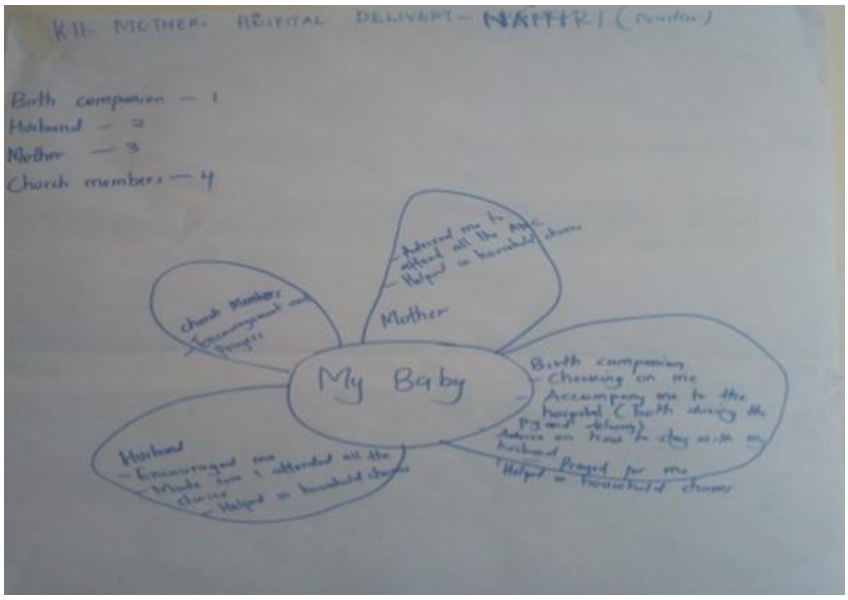

Fig 1: Flower exercise: A mother draws a flower showing the people and their importance during the birth and first months her baby's life.

BCs did believe that 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.

Front line health workers expressed unanimously their appreciation for the work of the BCs in ensuring that births take place in health facilities and that vaccinations are followed. They also mentioned the role of BCs in identifying early signs of complications and directing mothers to seek prompt medical advice. 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.

> *"It [the project] has impact also when BC accompanies the mother with the shortage [of staff] at the facility, when a procedure has to be done by two or more health workers but with the BC, you can instruct her to assist you with something. Do this, bring the linen; they are very helpful even they can when you have conducted the delivery you can instruct, we have hot water for them".*
> Midwife

However some also pointed out that there was a certain level of disappointment in the community, particularly among mothers, because they were not able anymore of benefitting from services previously offered by the TBA. Massages and dispensation of traditional medicine were among the services missed by mothers. In two groups it was mentioned that mothers felt rejected by new practices and BCs referring mothers to hospitals, was perceived as refusing to help them. Many of the BCs believed that massages still have a role and a few believed the traditional drugs still have a place. However we should also interpret these comments in light of the fact that the vast majority of BCs also expressed missing the income they generated in this way.

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 in light of 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 observation, 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 those in VSLAs and those not in VSLAs. 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.

3. Relationships and Community

A central dimension of our analysis revolves around the newly found respect that BCs enjoy in their communities. This was anticipated to 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 line with our expectations we found that BCs reported an increased level of self-esteem and a new status. Every single 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. Supervisors also agreed that BCs enjoy now greater recognition in their communities due to the knowledge and their new official role. 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.

As mentioned above, BCs reports on their improved status were overwhelmingly positive, but again we noticed that the rare negative experience tended to come mostly from those groups not involved in VSLAs. We saw the resentment of some BCs when their concern for the mothers they helped was taken for self-interest due to the incentives distributed by the project. In other cases the BCs expressed missing the relationship previously enjoyed with mothers and their role in bringing a new life into the world. However we equally heard how in some cases, the income generated as TBAs would cause friction within the household and how the practice of TBA was also disrupting family life.

> *"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

Every single FGD reported an increase in the respect that BCs enjoy in the community as direct consequence of the new role. This improvement in relationships touched different categories. Firstly the observations referred to the recognition within the community of their newly acquired knowledge and skills. This was paired with the pride of being asked to address public gatherings to spread knowledge and raise awareness on the importance of delivering at the hospital. Secondly the recognition of health workers was highly important to BCs. For many the improved relationships with health workers, both at community level (CHW) 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.

> *"What I can add is the relationships between health care workers and the BCs has 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.

Interestingly, the front line health staff reported having 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. Supervisors on the other hand, were not as quick to praise the role of the BC. As noted above, this can be clearly linked to the supervisors' perception that BCs are primarily motivated by income. In one case, we heard how a BC that waited for the mother she had taken to the hospital to deliver was interpreted as hanging around in the hope to receive money, rather than true concern.

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 even a calling. They believe they possess a special talent or purpose to provide comfort to mothers in pain.

Three quarters of the mothers drew a bigger 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.

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. Money and Time

The primary focus for our research was to better understand the extent to which the new practice would be maintained. 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 the new practice. The focus on money and time therefore stems from our awareness that, as TBAs, these women earned an income whilst the MANI project does not compensate them for making the transition to BCs. The very sustainability of the intervention rests on the assumption that BCs would continue to accompany or refer women to health centres and decline the opportunity to earn by assisting them at home.

> *"Mine [income] has increased because I get money when I attend MANI meetings*". BC.

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.

> *"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.

Every one of our FGDs reflected that the new practice had brought a reduction in income. The reduction in income referred to the in kind income with which they used to be paid for their services as TBAs. In addition to that, TBAs also used to enjoy income generated from massaging mothers and from dispensing traditional remedies. Both of them were deeply missed by BCs but also, reportedly, by mothers. Only a handful of BCs reported their income had remained the same, although some admitted that in previous times, occasionally, mothers would walk away without paying. In two of the FGDs, the group unanimously say that considerations on income should have been taken in the assessment. 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's interesting to notice that reference to mothers not paying for the TBA service typically referred to the birth, but not the massage during pregnancy. This is possibly because the massage can be delayed until a mother has some disposable income whilst the birth cannot be scheduled.

> A BC on the issue of loss of in-kind income: *"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.

Most of BCs reported being satisfied with the new practice, in general. But with regards to income generation, all of them reported that they had been disappointed. At the same time, they openly admitted that no promises of payment or employment were ever made by the project. In about a quarter of the cases, the women had expectations of becoming state employees. Due to the uniform provided by the project, some participants experienced demands of payment and support from the community as some of its members thought that they were, in fact, 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. 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.

In eight out of 12 FGDs, the BCs also mentioned with gratitude the income they receive from the project in the form of transport reimbursements and training allowances. Practically, in every case where a new source of income was mentioned as a replacement to the TBA work, this referred to that. It should be noted that these allowances and travel reimbursement will no longer be available after the end of the project. However the BCs did not appear to be aware of this. Those expressing their gratitude for the allowances were primarily from those groups that were not benefitting from the VSLAs. Whilst the BCs systematically expressed their gratitude for this income and even referred to what it has meant in their lives, including increased respect, we should nevertheless reflect on the temporary nature of this income and the risk to sustainability once the project ends.

5. Drivers for TBA practice

> *"I used to go to the hospital and when the doctors went on strike I decided to seek the TBA"*. Mother who delivered at home.

Half of the BC groups who participated in our research stated that they believed there still is a role for TBAs. Understandably they were reluctant to say this openly, but some quoted other traditional services offered, primarily massage but also dispensation of traditional drugs as an example of the role TBAs can still play. Others raised the issue of emergencies when there is not enough time to reach the hospital. Health workers never acknowledged that TBAs could still have a role; however they acknowledged that the fear of charges was a main barriers for mothers, although they noted that there should be widespread knowledge that the hospital service is free. The mothers who were interviewed all had planned to deliver at the hospital, including all the mothers who had given birth at home. In some cases they were not able to reach the hospital on time whilst in others the health workers' strike was the reason for not being able to deliver at the hospital. Dramatically one of them was turned away from the hospital because she was told that she had turned up too soon but the baby was then born in the middle of the road at an intersection on her way back home.

However, we should also note that many BCs reported that some mothers that do not wish to give birth at the health facility, deliberately wait too long before seeking the help of a BCs as a way to manipulate them into helping them deliver at home.

Not all mothers are happy to go to the health facility for a variety of reasons.

Transport costs were among the reasons quoted, as well as the fear of having to pay hospital charges particularly during the strike when they had to go to other private health facilities. However, by far, the most dominant reason for mothers to fear a delivery at a health facility comes from the attitudes and behaviours of the staff themselves. (See section below).

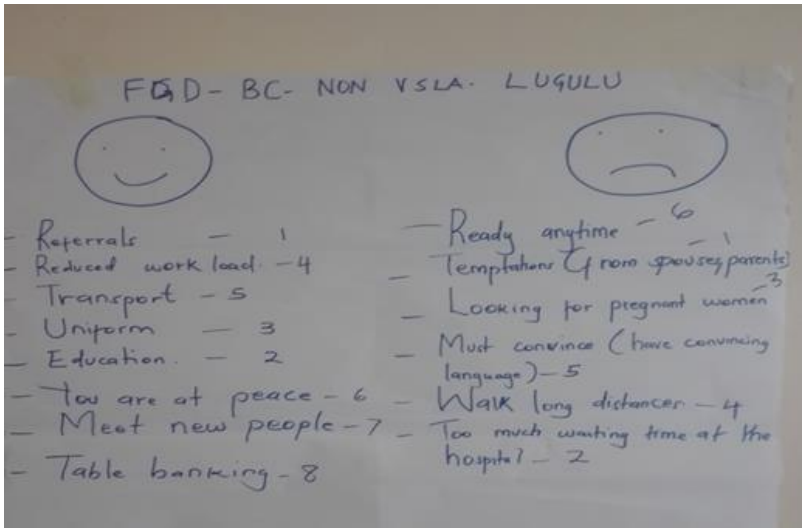

Fig 2: Likes and dislikes of a BCs group that does not benefit from VSLA.

A key part of the research focused on understanding drivers and incentives that might motivate our BCs to revert to TBA practice, besides demand for TBAs in the community. When we analyse the trends that emerged, we see that they neatly fit into three broad categories:

5.1 Cultural and emotional drivers
5.2 The demand side
5.3 The supply side

5.1 Cultural and emotional drivers

"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.

Even though all the BCs were widely complimentary about the projects' work, 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 a good part 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. From the perspective of the MANI project it's therefore interesting to see how their presence during the delivery is valued much more by front line health workers than by supervisors.

The relationship and connection between mothers and TBAs is missed not only by the TBAs but also by the mothers. The soothing traditional massage is definitely missed by the mothers and this is also acknowledged by health workers. Some of our BCs also report that mothers feel rejected by the new practice and feel that the TBA is refusing to help them by directing them to the health centre. 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 the simple income. Frequently many of our BCs reported, when directly questioned,

"My work has been eased by the introduction of BC and also, you see a mother feels comfortable when in labour and somebody is there for her like back massages, encouragement. You see when you are alone and on duty sometimes you have 3 mothers in bed so that BC can assist". Front line health worker.

that they believe there still is a role for TBAs. Some described with a great deal of emotion their role and how they now suffer from the restrictions in place by 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 find them hugely 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 only aided only by a complete stranger, 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].

5.2 The demand side

Whilst there is increased awareness of the importance and benefits of a delivery attended by medical professionals, the demand for TBA work does not appear to have completely disappeared. BCs reported that many mothers still prefer to be attended to by a friendly local woman. This preference is also acknowledged by health workers. None of the mothers we interviewed admitted preferring the services of a TBA but this is understandable in light of the mandate of our research. Among those interviewed, only one mother who made use of the services of a TBA (although had originally planned to go to the hospital), said that her reasons were her personal attachment to this particular TBA.

> "*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'

Our BCs reported occasionally having to convince mothers to go to the health centre against pleads to deliver the baby at home. We also heard how some mothers delay contacting the BC until labour is so advanced that the only option is to deliver the baby there and then. In one instance we heard of a mother crawling to the BC's house on all fours since labour was so advanced she couldn't stand. The reasons for this preference are of two kinds. For a minority, the cost of travel, the distance and the fear of charges is an issue, but for the majority, the attitudes and behaviours of medical professionals is the main deterrent. In every single FGD our BCs, normally unanimously, reported that the main barrier to a universal adoption of the new practice were the attitudes and behaviours of medical professionals. They reported mothers' perceptions that an unwelcoming, humiliating and often abusive reception awaits them at the health centres. Healthcare professionals also frequently acknowledged this perception but never accepted 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, sympathetic and soothing behaviour of TBAs over that of medical professionals. Repeatedly, they also acknowledged the lack of resources whilst falling short of directly admitting this led to uncaring behaviour. Reading between the lines, however, it is hard not to give any credence to these 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 over 40s mothers fear mockery and derision and this deters them from

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

attending the facility. This is not acknowledged by the health professionals who nevertheless recognise 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 nice and polite behaviour TBAs provide, 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, in spite of translation, 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 and that our note takers did not make any confusion between the two equally unacceptable behaviours. We should also note that only one of the mothers interviewed reported being harassed and 'chased' out of the hospital for arriving too soon before the birth. (This is the woman described above as having given birth at an intersection, page 12).

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 area, 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 reasons for asking women to lie on their beds to give birth, we should nevertheless stress that if we want to see increased attendance at the health centres we should be more flexible in allowing patients to choose what feels most comfortable to them and show greater respect for their cultural beliefs.

A further two health centre practices were also reportedly a deterrent for women: the prevalence of male staff and HIV testing. The fear of being attended by a male doctor or nurse was reported in several occasions as being behind the reason why mothers would delay seeking help and in extreme cases 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 never reported such preference and were adamant that the presence of male staff was in fact a cultural barrier.

The fear of HIV testing was qualified in two different ways and acknowledged by both BCs and health professionals as a deterrent. The fear of finding out one's status was the prominent one but for a small minority the fear of exposure was also a factor.

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 the 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.

5.3 The supply side

Systematically, all the BCs in our study acknowledged that their income had decreased when they stopped practicing as TBAs. Their loss was not simply the compensation they would get for delivering babies but also the in-kind income they would receive for this service, for the massage and for traditional medicine (including abortion procurement). As observed above, many acknowledged that the project had in part replaced that income by providing transport reimbursement and training allowances. However, in

most cases this income was not equivalent to what most BCs believe they generated before. 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.

6. VSLA

MANI project trained and established 7 VSLA groups within the existing BC across Bungoma County 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 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*". A BC involved 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 accompaniment.

Systematically and often unanimously members of VSLAs expressed their appreciation for the intervention and explained it 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 didn't lead to the creation of a VSLA.

> "*The expectations were so high, but if we compare with now all have been covered through the VSLA because 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*." A BC involved in VSLA.

As noted above the BCs who also participated in VSLAs also appeared to be more positive about the project in general and explain the value of the MANI project with arguments centred on improved practices and knowledge, rather than fear. It is therefore interesting to explore here the top dislikes expressed by groups involved in VSLAs. The BC groups not involved in VSLAs focused their gratitude for the project on preventing deaths and risks. This thinking is also reflected in their dislikes. Conversely the dislikes of groups participating in VSLAs were more concentrated on two topics: the voluntary nature of the work and the problems with the transport arrangements. It is fascinating to see that the voluntary nature of the BC work was not brought up as dislike by those not participating in VSLAs as one would assume. This highlights how 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 favourite. 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 abandon 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, it is difficult to see how the BCs will

abandon their new businesses to accompany mothers to the health centres particularly given their frustrations with the transport system, which will no longer be subsidised by the project.

Conclusions and Recommendations

From the evidence reviewed, it clearly appears as if **the MANI project has been successful at shifting communities' attitudes in favour of mothers delivering at health facilities**. None of the mothers we interviewed had wished to deliver at home and where that happened, it was not planned that way. **None of the BCs envisaged going back** to their old practice, partially because of their better understanding of the risks among the communities, but also because of the recognition they receive in their new role. However, our research highlighted that there are still three main factors that could drive TBA practice in the communities:

1. Transport from village to health facility
2. Financial incentives that TBA practice generates
3. Attitudes of mothers and health professionals

The MANI project took all three factors into consideration and was considerably successful at sustainably addressing some, but not all.

1. Transport from village to health facility

In spite of the complaints raised about the safety of the motorbike rides and the reliability of the drivers, it is clear that the provision of transport vouchers was very well received and has been pivotal for mothers to decide delivering at the hospital. However, it is not clear if all women will be able to spend their own money to travel to the hospital after the project's end. There is indeed, evidence suggesting that community members have been persuaded, including husbands, of the need to pay for transport, but we also heard from BCs that occasionally women refuse to pay for the TBA assistance and that in some cases they were so poor they did not even have a piece of fabric to wrap their new baby in for the way home after delivery. It is hard to imagine that these very poor women would be able or willing to pay for a motorbike ride to the health centre once the project comes to an end. Whilst it is possible that they might do so for the birth, it is questionable whether they would pay to attend ante natal care and vaccination follow up appointments, since BCs reported having to work hard to persuade women to attend these.

It is also highly 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 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 makes her way to the BCs house, as they were instructed to do during the project, only to find that transport is no longer free. In this scenario, it is not entirely unconceivable that the BC, particularly one that is not engaged in a VSLA, could be persuaded revert to TBA practice.

2. Financial incentives TBA practice generates

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. The transport reimbursements and training allowances provided by the project has 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 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, the part of TBA work they least enjoyed. Another main source of income for TBAs was the provision of massages and traditional medicines for women. 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 and 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 this service, but it does not appear to have been equally successful at reducing the demand from mothers. Mothers reportedly would still like to enjoy their massages and often feel rejected when they are refused. Interestingly whilst some BCs mentioned that occasionally mothers would not pay for the TBA's services, they never reported lack of payment in relation to massages or traditional drugs. In this sense these services were a safer source of income for the TBAs.

3. Attitudes of mothers and health professionals

In conclusion, the attitudes of mothers and communities have undoubtedly changed in favour of professionally attended births. This shift is probably not exclusively attributable to the project but, as noted by many health professionals, there have been several initiatives that aimed at encouraging mothers to attend the clinics. From our evidence, it is unquestionable that community members, mothers and more and more frequently husbands are persuaded of the importance of giving birth at a health centre. The majority of them are in principle, willing to pay for their transport costs, whenever they are able, although probably less so for antenatal care. However, the one area that still appears to be highly problematic concerns the perceptions of the attitudes and behaviours of health professionals. The fear of abuse emerged as a main factor driving mothers away from health facilities. 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 warm, compassionate and gentle treatment 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**. On this particular area, the MANI project should take a stronger stance and better capitalise on the established network of BCs. Patients attending health facilities should also be confident that their cultural and religious beliefs will be respected. In 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 the instance on assuming a particular position for the birth was a major cause of grievance. Regarding the practice of enforcing a certain birthing position, as reported by the BCs, this was also echoed by the health professionals themselves. The final form of reported inappropriate behaviour relates to ageism whereby younger and older mothers fear derision. Without mentioning this directly, we noted that health workers for their part recognised that these two categories are less likely to attend the facilities.

For mothers, the fear of encountering these behaviours, whether real or perceived, represent a major deterrent in using health facilities. Furthermore, if indeed practiced, ageism, harassment and hitting are all violations of human rights and have no place among the caring profession.

There are a few recommendations that emerge from our study that raise a few options for additional activities or initiatives that could help consolidate the gains of this project.

1. Explore the opportunity to **expand the VSLA** formation activity that has proven so successful to all of the BC groups. As noted throughout the report VSLAs, have provided a strong motivation and have unanimously been reported as a successful addition to the model.
2. The MANI project should seriously consider how it can best address the presence or perception of what has been referred by BCs and mothers as 'disrespectful' behaviour from health professionals. The wording and examples given by the BCs and alluded to by health professionals, points more towards gender-based violence. The MANI project should consider ways in which it can support a culture shift towards the full respect of human dignity, from respect of religious and cultural norms to the protection from physical violence and verbal abuse.
3. Whilst not compromising on this stance, the MANI project should consider ways to support overstretched medical professionals to adopt a kinder and more respectful behaviour to mothers, so they are not made to feel guilty.
4. The project could consider raising awareness among the communities about care standards, patients' rights and appropriate complaints mechanisms.
5. The project should consider **capitalising on the network of BCs for feedback from the community** on what might put in jeopardy the new practices. The MANI project has been extremely successful at utilising this network to propagate the message, but appears to have missed the opportunity to use the BCs ears in the community. Clearly the BCs enjoy a good relationship with women in the community and have access to information that is valuable to the project.
6. Linked to the above point, the MANI project should consider initiating a dialogue and perhaps some training with health professionals and women in the communities in relation to other birthing positions, in order to identify an alternative that is satisfactory to both mothers and health professionals. Currently, they are clearly not able to do this. It is possible that this relates to hospitals procedures and there might be many valid reasons for this, but **standard practice should be rebalanced on the side of the patient's preference**. Where appropriate the MANI project could consider providing some additional equipment to health centres such as birthing chairs or mats in order to encourage, at the very least a compromise between the preferences of women and those of health professionals.
7. **Initiate dialogues with all hospital staff** across the sub-county to promote better understanding between BCs and health staff and in particular reflect on the following:
    a) Explore the reasons why some BCs are reportedly banned from accompanying mothers in the delivery room. This has been mentioned as a cause of distress for mothers, particularly when they do not speak the language and need the cultural mediation provided by the BC.
    b) Ensure greater consistency in the treatment BCs receive from health facilities staff. Some BCs reported low levels of respect for their role. This also transpired from interviews with health professionals. Not being respected by health professionals is of particular importance for those former TBAs who are truly passionate about their vocation.
8. The project should **consider if a more flexible stance on traditional massage** could prevent BCs from reverting to TBA practice. Aside from the loss of income felt by al TBAs/BCs, the massage in particular is a source of enjoyment and bonding for mothers and BCs. It might be in the projects long term interest to investigate ways in which the TBAs/BCs may be trained to ensure the practice is not harmful to either mother or baby; allowing BCs to continue earning from the practice and allowing mothers to enjoy the personal care they receive.
9. Finally the MANI project should consider **issuing certificates** for BCs since this has been a source of discontent that can be very easily addressed. This might also provide an entry point for raising greater **awareness about the impending end of the project** and its implications, particularly in relation to the end of transport subsidies for which BCs appear not to be prepared.