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The experience of being a traditional midwife: relationships with skilled birth attendants

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ABSTRACT

Introduction: This article focuses on an unexpected finding of a research project which explored the experience of being a traditional midwife. The unexpected finding was that traditional midwives often perceive skilled (professional) birth attendants to be abusive of both them and the women who are transferred to hospital for emergency obstetric care.

Methods: Eighty-four traditional midwives in the Western Province of Kenya were interviewed individually or in groups with a Bukusu/Kiswahili/English-speaking interpreter. Interviews were audiotaped and the English components were transcribed verbatim. Interview transcripts and observations were thematically analysed.

Results: A minority of relationships between traditional midwives and skilled birth attendants were based on mutual respect and collaborative practice. However, the majority of encounters with skilled birth attendants were perceived by the traditional midwives to be abusive for them and the women requiring emergency obstetric care. In the interests of improving health outcomes for women and their newborns, interpersonal skills, including maintaining respectful communication and relationships must be a core competency for all caregivers. Providing opportunities for reciprocal learning and strategies to enhance relationships between traditional midwives and skilled birth attendants are recommended.

Conclusion: Current global strategies to reduce maternal and newborn mortality by increasing the number of women birthing with a skilled (professional) birth attendant in an enabling environment may be limited while the reasons for traditional midwives being the caregiver of choice for the majority of women living in areas such as Western Kenya remain unaddressed.

Key words: birth attendant, Kenya, kindness, skilled birth attendant, traditional midwife.

Introduction

The research project informing this article explored the experience of being a traditional midwife (TM) in the Western Province of Kenya and the impact of AusAID funded resources on their practice[1]. An unexpected finding of that project is the focus of this article: TMs' reports of abuse and assault by skilled birth attendants (SBAs) when TMs transfer a woman to hospital in an emergency.

For the purposes of this article, a TM is a person who provides intrapartum care for women and who has usually learnt their skills in a mentorship/apprenticeship model but has not satisfactorily completed a prescribed course of study for licensing as a midwife in Kenya. In contrast, a SBA is defined by the International Confederation of Midwives (ICM) and WHO as a health professional (medical practitioner, nurse or midwife) who has acquired the formal qualifications to enable their legal licensure[1]. A TM is usually referred to as a traditional birth attendant (TBA) by organisations, including the ICM and WHO. However, the nomenclature used in this article is TM, in acknowledgement of the term used by women, health professionals in this area and the participants.

A search of the literature yielded many articles discussing maternal and newborn mortality rates (MNMR), and skilled/unskilled birth attendance but very few specifically explored how TMs and SBAs related to each other[2,3] and none explored the relationship from the perspective of the TM. One text provided multiple international case studies of effective maternity service models[2]. Showcased models from Mexico[4], Samoa[5] and Brazil[6] all adopted similar principles which associated the integration of TM and SBA care with consequent positive outcomes for women and their newborns.

In contrast, there were multiple instances where SBAs, armed with higher education levels, authoritative power, obstetric technology and symbolic appearances such as uniforms, exerted power in a destructive, de-humanising and abusive way over women and TMs[7-9]. Examples of rude, bullying, abusive, intimidating and even violent SBA behaviour are not limited to sub-Saharan Africa but have also been reported in literature describing maternity care in both resource-rich and resource-poor nations, including Afghanistan[10]; Australia[11]; Laos, the Philippines and Thailand[7]; Mexico[12]; Nepal[13]; UK[14] and the USA[15,16]. The voices of TMs were silent in this literature.

Between 1978 and the mid-1990s, global policies including those from WHO identified the potential of TMs to provide valuable intrapartum care, especially in world areas where resources, including health professionals, were very limited[17]. Since the mid-1990s, global policies and organisations have not supported the utilisation, resourcing or training of TMs but have focused on increasing the number of women accessing SBAs[17]. It is argued that this change in policy direction occurred without rigorous evidence that it would improve the MNMR[17]. Furthermore, this change was based on lower grade evidence that is historical, observational and experiential and has impacted on sub-Saharan African women more than any other population group[18]. Contrary to expectations, policy changes have failed to make the anticipated improvement in MNMR. For example, the maternal mortality rate in Kenya is estimated to be 560 per 100 000 births, with no sustained improvement since 1998[19]. The lifetime risk of Kenyan women dying from childbearing-related factors remains at 1:22 (compared with an Australian woman's risk of 1:7300)[19]. Traditional midwives, no matter how skilled in their midwifery practice, continue to be held responsible for the high MNMR[17] while social factors such as poverty, gender inequity, war/regional conflict, unsafe and unavailable emergency care, inadequate transportation, malnutrition and low levels of literacy, all of which impact MNMR, are ignored[20].

In contrast to promoting the practice of SBAs only in an enabling environment, there is a second school of thought in the literature. This alternative argument is that because there

are universal components to safe and effective maternity care, a key strategy to reduce the MNMR is to respect the practices and knowledge of TMs[2,17]. This argument promotes the development of culturally sensitive, practical and effective training programs for TMs, in places where they still practice[2,17].

This article provides an in-depth description of the relationships between TMs and SBAs, from the TM perspective. The voice of the TM is pivotal in the discussion, and recommendations are made for improving these relationships for the benefit of all, especially the childbearing woman and her newborn.

Methods

The research was set in the Western Province of Kenya, one of the most disadvantaged areas of this resource-poor nation. The province is slowly recovering from drought and the post-election violence of early 2008[1]. Most people in the area live in rural villages, as do the TMs who are well known in their communities. Between 75% and 90% of all birthing women in this area utilise the services of a TM during labour and birth (S Kibuywa, policy analyst; pers. comm.; 13 January 2005). The author, an Australian midwifery academic, has worked with two of the TM participants as well as many SBAs during annual faculty practice in Kenya and the Democratic Republic of Congo since 2004.

Eighty-four participants identified or self-identifying as TMs provided informed consent to be interviewed either individually (18 participants) or in groups (66 participants). Twenty-four of the participants were invited to participate in the study initially because they were identified as TMs who belonged to networks established by the African Non-Government Organisation (NGO), the Mission in Health Care and Development (MHCD) to provide opportunities for peer support, dissemination of AusAID-funded birth kits and ongoing education. All 24 of these TMs agreed to participate. The remaining 60 TMs were recruited through an unanticipated snowballing effect when they were informed by participants about the study and also requested to be interviewed as individuals or in groups. All participants had provided midwifery support for at least one woman during labour and birth in the 3 months preceding the interview. Participants were reimbursed for travel costs and received light refreshments during the interview but there was no other incentive, apart from their desire to share their experience of being a TM.

Of the 84 participants, 83 were female and one was male. Few knew their exact age but most appeared to be in their 40s, with an age range of from 18 to approximately 80 years. All female participants had birthed themselves but their inclusion in the study was as a TM rather than a childbearing woman. In contrast to SBAs, their literacy levels were generally very low, as evidenced by more than half the participants signing their informed consent form with an 'x'.

A qualitative research design, exploratory in nature, was used to gather data during semi-structured interviews, and from field notes taken during and immediately after interviews about the experience of being a TM and the impact of AusAID-funded resources on their practice[1]. It was not the intent of the study to collect data about the relationships between participating TMs and SBAs and this data was not requested, but it was spontaneously shared by participants during interviews.

The author facilitated each interview and was assisted by a Bukusu/Kiswahili/English interpreter. Non-specific, open-ended prompts were used to avoid influencing participants' responses. Prior to interview, participants were informed about what they might be asked to share and that this may include: information about their role and practice as a TM; when, where and how they learnt their midwifery skills; the services they offer women and the records they keep; what they enjoy and fear most about being a TM; the impact of birth kits on their practice; and anything else they would like to share about their experience of being a TM. It was stressed that the participants' experience was important, and that the interviews would follow their lead.

Each interview opened with the request, 'Please tell me as much as you can about what it is like for you to be a traditional midwife'. Conversational prompts were then used to clarify issues and encourage the participants to describe phenomena in greater depth. Venues for interviews included participants' homes, fields, village meeting places, clinics and church halls.

All English language components of interviews were transcribed verbatim. Data from transcribed interviews and observational field notes were thematically analysed by the author working with the research assistant, an African medical practitioner. Themes identified by paired consensus of both researchers were selected. The primary theme that being a TM is about being in relationship with others had a sub-theme relating to their relationships with SBAs.

Practical considerations precluded returning the transcribed interviews to participants for discussion and/or verification. These considerations included the low literacy levels of the participants and their distribution over a very large geographical area with extremely limited transport and no postal services outside the town area. Therefore exemplars, using the participants' translated words, were identified using paired consensus by the author and research assistant and were used for analysis and presentation purposes.

As the only affiliated organization with an institutional ethics committee (IEC), Charles Sturt University IEC approved the project (2009/45). Community consultation and careful consideration of cultural values occurred prior to and during recruiting of potential participants (and two interpreters/cultural advisors). There are no known professional interpreters in the geographic area and, therefore, two suitable interpreters were selected by the research assistant and employed for the purpose. Selection criteria included fluency in the Buskusu/Kiwahili/English written and spoken languages, female sex, ability to provide cultural advice and having no previous affiliation with either TMs or SBAs (to help ensure translations were literal). Cultural advice included but was not limited to whether or not contracts should be established prior to group interviews.

All participant information about the study and informed consent forms were written in Kiswahili (the primary written language of the area). However, given the low literacy levels of most participants, written information was backed with oral explanations in the Bukusu/Kiswahili language by the research assistant and/or the interpreter. The research was conducted in compliance with all relevant laws and at all times conformed to the provisions of the Declaration of Helsinki in 1995 (revised Tokyo 2004).

This research project was set in one area of inland Kenya and so its findings may not be generalizable to other areas in Africa. While data were collected from 84 TMs, 83 of whom had birthed in the area, data were not collected from SBAs nor childbearing women who were not TMs. These are limitations of the study which require redress in future research.

Results

The primary theme identified during data analysis was that being a TM means being in relationship with others. This theme had a number of sub-themes including relationships with women and SBAs, based on participating TM reports of their relationships with SBAs.

Participants provided four examples in total of TMs and SBAs working together with mutual respect:

> *mostly [I] learnt in 1991 ... there were special doctors from away. Then I learned in 1995 with a group of local doctors who taught here.* (Participant 24)

> *The seminars, you can go there ... and you can learn how you can [assist the woman] if you have a problem. A doctor and a midwife, you can go there and then you have different experiences from different people ... I enjoy it because it show me many things.* (Participant 11)

> *[Uterus came right out] ... [I] just pushed the dirty uterus inside the stomach then [I] just pour wet water in mamma's vagina ...clean water ... Then that*

> *mamma was slept down for about 15 minutes [unconscious], then she wakes up ... take her to the hospital ... Just for 2 days ... the doctors treated her ... she's had 5 more [babies] after that ... no problems.* (Participant, group 2)

> *When [I] transfer a woman to the hospital now ... they just attend to her immediately. Now even the doctors send their wives to [me].* (Participant, group 1)

In contrast to these exemplars of respectful relationships with SBAs, 36 participants gave unsolicited exemplars of perceived abuse. The participants commonly believed they were being blamed by the SBAs for labour and birth complications:

> *When you reach [the hospital], the doctors and the nurses will not attend, they'll even abuse you. They'll tell you, you are the cause of all these problems.* (Participant, group 1)

> *They are very abusive. They even don't want to care.* (Participant, group 20)

The participants reported that SBAs abuse women and TMs, providing them little support, discouraging them for accessing services and, on occasions, denying them access to medical care in an emergency:

> *They'll give you back that patient, and you continue with what you've been doing while you're at home, so it becomes a problem to me as a midwife... [I] take the woman, an emergency, to the hospital, the doctors and nurses abuse [me] and refuse to see that woman.* (Participant, group 1)

Some participants believed that refusal to treat a woman in an emergency may be due to professional jealousy and resentment of the TMs:

> *Sometimes they can abuse the patient and leave her alone ... because they wanted that patient to go direct to the hospital, not to us first. Hospital midwives are jealous [of us] ... they become very jealous ...they don't want anybody to come to us ... they only want women to come to hospital to them.* (Participant, group 19)

> *The women don't go to the hospital ... If a woman goes to the hospital in an emergency ... They almost chase her away or they not treat her well... They say, where are you from, you are going for a midwife so go to that midwife to assist you not here... So the hospitals do not like the women to come in, in an emergency.* (Participant, group 7)

Even emergency treatment could be dependent on the woman's ability to pay:

> *[If the woman cannot pay, doctors and nurses at the hospital] will not attend to [them], and that's what we are telling you; because of that, the child will be lying in the room and have to die, so they are risking the child plus their mamma.* (Participant, group 1)

The participants alleged that it is common practice for the woman to be detained in the hospital postpartum, until her family can pay the ever-mounting government or private hospital bill:

> *If the mamma does not have that money to pay ...They will detain [her] there ...And then [she] pay...And the amount going up all the time.* (Participant, group 20)

The participants all expressed a desire to stay with the woman when she was transferred to hospital, but this was rarely allowed. Traditional midwifes believed their presence may serve to advocate for the women and prevent women from being abused by the SBAs, and that this was the reason they were not allowed to stay:

> *They just abuse with their patients ... they tell us to go out ... they don't want us to see what is going on with that patient. Because maybe they are hurting them, they are abusing them.* (Participant, group 19)

Reports of physical violence by some SBAs against labouring and birthing women were common:

> *The nurses in the hospital ... they beating [the woman] ... they beat the women, beat*. (Participant, group 20).

> *The [women] don't make noise, they are just waiting for [their] baby ...the hospitals tell the women to hush ... just tell [TM] to move, wait outside there, and don't make noise, they tell [her] like that. And they can slap [her]. And slap [the woman].* (Participant, group 9)

Reports of intimidation and assault were perceived by the participants to be due to SBAs trying to sabotage the TMs' role and reputations:

> *They don't want midwives to succeed. (Participant, group 19)*

Discussion

Collaborative practice has the potential to be life-saving for birthing women. It has been argued that the MNMR will be reduced when social factors such as gender inequity, poverty and its associated infrastructural deficits are addressed[20], and when TMs are treated as colleagues and potential lifesavers, rather than unskilled, under-performers[21,22].

The TMs perceive that they are being blamed for complications and that this may be the cause of the abuse they report. With the exception of the participant who said that the doctors referred their wives to her, the only interactions with SBAs described by the TM participants were in the context of transferring a woman to hospital in an emergency. When a woman who has planned a homebirth is transferred to hospital by a midwife, abuse of the woman and midwife by hospital staff is not limited to the Kenyan setting. It is a common phenomena[2,23] that has been described in the American[15] and Australian context[24]. It has been argued that that abuse of women is due to hospital staff experiencing time pressures and frustration at their own inability to provide the kind of maternity care they idealise, with the result that they abuse the person/s less powerful than they[24]. In this study, the less powerful include TMs and birthing women.

The literature provides a number of alternative explanations for SBAs acting aggressively. It has been suggested that the SBA responds out of fear, because the medicalised model of birth in which they practice is underpinned by fear and dependent on professional and community fear of birth for its existence[25]. Skilled birth attendants may fear for the wellbeing of the woman and fetus, feel inadequate in dealing with complex situations with limited resources, and may respond by abusing the woman and the TM. Other explanations for abusive caregiver behaviour toward labouring women range from professional insecurity to feelings of superiority to TMs and women[26]. Whatever the explanation, when SBAs are abusive, they put lives at risk by discouraging access to emergency obstetric care.

There have been reports of SBAs abusing women and TMs, providing them little support, discouraging them for accessing services and, on occasions, denying them access to medical care in an emergency[27]. Even emergency treatment can be dependent on the woman's ability to pay.

Reports of intimidation and physical assault of women by some SBAs is not limited to the participants of this study. This has also been reported in countries as diverse as the Democratic Republic of Congo and the USA[16,28]. Abuse of women is thought to be particularly severe when a woman was transferred from home to hospital in an emergency; hospital midwives have been observed trying to sabotage the role and practice of homebirth midwives in both the USA and Australia[15,24]. Whether attempted sabotage is perceived or actual, in this rural setting in Kenya, it is the antithesis of

the collaborative practice required to reduce the MNMR by encouraging women and TMs to access obstetric care in an emergency.

Recommendations

In Western Province of Kenya, the large majority of women either choose, or have no option other than to choose, intrapartum care with a TM rather than a SBA. Encouraging integrative, collaborative and mutually respectful TM and SBA relationships and practices will benefit women. When developing health policies, the opinions and preferences of women must be acknowledged and the practice and experience of TMs recognized. Interpersonal and communication skills that demonstrate reciprocal respect should be a valued core competency for all caregivers. Technical competence (which may or may not be based on evidence and best practice) must not be the sole criteria on which to base the skills assessment of any caregiver. Furthermore, caregiver kindness (the opposite of some SBA behaviour reported by participants) should be valued along with knowledge and technical competence as a means to enable safe practice[29].

There are both policy and practice implications in the findings of this study. In recognition of the majority of women's continued utilisation of TMs as caregiver in this area, it is recommended that policies return to resourcing and providing ongoing education (that is culturally safe and based on best available evidence) to TMs and SBAs alike[20-22].

Practice implications impact on both SBAs and TMs. Effective birth models encourage SBAs to spend time working with and learning from TMs, where they still exist in the community[30]. To be effective, the usual assumed roles must be reversed so the TM becomes the teacher and expert in 'out of hospital' care. The SBA, with an attitude of cultural humility, could learn from the TM how to be with and support labouring women in the community. Time spent with TMs would have the secondary benefit of increasing understanding of why the majority of women in this area prefer to birth outside the hospital with a TM. As Fathalla argued, 'The question should not be why do women not accept the service we offer, but why do we not offer a service that women will accept' (pvii)[31].

It is not suggested that TMs have nothing to learn from SBAs. Rather, sharing of knowledge should not be valued only when the SBA teaches the TM. Both should have the opportunity to communicate and learn from each other in the home/community and hospital setting as equal partners. The findings of this study affirm the value of resourcing participating TMs with simple birth kits and the opportunity to attend workshops/seminars on evidence-based, woman-centred midwifery care, which are facilitated by professional caregivers. In the interests of enhancing collegiality and SBA–TM interactions outside the emergency context it is recommended that such workshops be made available to local SBAs as well as TMs.

Future qualitative research is required to provide a balanced perspective and also give the SBAs a voice. Although almost all the participants were women who had birthed in the area, as well as being TMs, future research must also consider the experience of childbearing women who are neither TMs or SBAs. Furthermore, the outcomes for women and their newborns accessing TM services, compared with those accessing SBA care in a hospital setting, need to be determined through future mixed methods research.

Conclusion

The participants illuminated why they believe the TM is the caregiver of choice for the majority of women in this area of rural Kenya. Current global strategies to reduce the MNMR focus on increasing the number of women birthing with a skilled (professional) birth attendant in an enabling environment. Such strategies may be limited as long as the reasons that TMs are the caregiver of choice for the majority of women living in areas such as the Western Province of Kenya (the research setting) are not given consideration.

The resourcing of maternity services must consider the context of service delivery and address the social determinants that impact on the MNMR in sub-Saharan Africa. It may not be the status of the caregiver that will have the most influence on the MNMR. Collaborative practices that identify the experience of TMs and SBAs alike and value collegiality and reciprocal learning have the potential to optimise health outcomes for the woman and her newborn, especially when services are required to manage obstetric complications. Skilled birth attendants treating women and the TMs who may accompany them with kindness, patience and respect may encourage women to access SBAs and help provide an enabling environment for the woman requiring obstetric care in an emergency.

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