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CLINICAL ARTICLE

Changing the role of the traditional birth attendant in Somaliland

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ABSTRACT

Objective: To explore the feasibility of changing the role of the traditional birth attendant (TBA) to act as birth companion and promoter of skilled birth attendance. *Methods:* Between 2008 and 2012, 75 TBAs received 3 days of training and were paid US $5 for each patient brought to any of five healthcare facilities in Maroodi Jeex, Somaliland. Health facilities were upgraded (infrastructure, drugs and equipment, staff training, and incentivization). Eight key informant interviews (KIIs) and 10 focus group discussions (FGDs) involving 32 TBAs and 32 mothers were conducted. A framework approach was used for analysis. *Results:* TBAs adopted their new role easily; instead of conducting home births and referring women to a facility only at onset of complications, they accompanied or referred mothers to a nearby facility for delivery, prenatal care, or postnatal care. Both TBAs and mothers accepted this new role, resulting in increased deliveries at health facilities. Facilitating factors included the creation of an enabling environment at the health facility, acceptance of the TBA by health facility staff, and monetary incentivization. *Conclusion:* Changing the role of the TBA to support facility-based delivery is feasible and acceptable. Further research is needed to see whether this is replicable and can be scaled-up.

1. Introduction

Access to a skilled birth attendant (SBA) is critical for improving maternal and newborn health [1]. In low-resources settings and rural areas, professionally trained staff are often in short supply and there is a tendency for women to rely on traditional birth attendants (TBAs) for delivery [2]. Studies have shown that, although a modest reduction in newborn deaths can be achieved when TBAs are trained and supported, a reduction in maternal deaths does not occur [3–5]. Discussion continues around, first, the role of the TBA; second, the best way to include these experienced women, who are respected and trusted by the community in the provision of the continuum of care; and third, if they are to continue to act as community-based providers or promoters of maternity care, how to ensure that they are linked with the existing health system [6].

A TBA is defined as a person who assists a mother during childbirth and has acquired her skills by delivering babies herself or through apprenticeship to other TBAs [7]. TBAs provide care during pregnancy, childbirth, and the postpartum period; and are well established, living in close proximity to the women who require maternity care in the community. They have detailed knowledge of community norms and are paid "in kind." These characteristics are increasingly considered as strengths that the formal health sector has sought to leverage [2].

Many women living in low-resource and rural settings continue to seek the care of a TBA, despite the knowledge that a health facility delivery is often safer [8,9]. Until recently, the scope of TBA training was designed to prepare them to recognize "at risk" mothers and newborns, to conduct a safe home birth for low-risk women, and to refer women considered to be at risk or to have recognized obstetric complications to a health facility [6,10]. WHO's new guidelines for the practice of TBAs suggest that providing companionship and support during pregnancy and birth, in addition to health promotion are the roles best suited to the TBA skills [11].

Somaliland, which has comparatively poor health indicators (Table 1), relies heavily on TBA-assisted maternity care owing to a shortage of all cadres of skilled healthcare providers including SBAs [12]. In 2008, a program to improve the reproductive and sexual health of internally displaced people (IDP) was implemented in the Maroodi Jeex region of Somaliland. In this program, TBAs received training and orientation in order to practice as health promoters and birth companions, instead of their traditional role of conducting deliveries at home and referring women to a healthcare facility only when complications arose.

The primary aim of the present study was to examine the acceptability and feasibility of reorienting the TBA role by documenting the experiences of both TBAs in their new role and mothers who had received care from a TBA, in addition to the perceptions of key health system stakeholders. Documentation of experiences and lessons learnt will

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Table 1
Maternal and child health indicators for Somalia and Somaliland.[a]

Indicator	Value
Somalia	
Average life expectancy at birth	50 yr
Maternal mortality ratio (MMR)	1000 per 100 000 live births
Risk of a woman dying during child birth	1 in 16
Mortality rate: under 5 yr	180 per 1000 live births
Mortality rate: infant	43 per1000 live births
Somaliland	
Prenatal clinic attendance (at least one visit)	32%
Skilled birth attendance	44%
Home birth	75%
Overall fertility rate	5.9%

[a] Data from References [12–14].

inform international practice and help to decide whether this model can be replicated in other low-resource settings.

2. Materials and methods

The program "Improving the Reproductive and Sexual Health of IDP, Maroodi Jeex, Somaliland," was implemented from January 1, 2008, to December 31, 2012, by Health Poverty Action (HPA) in partnership with the Liverpool School of Tropical Medicine (LSTM) and the Somaliland Ministry of Health (MOH). The study was conducted among IDP and returnee communities encamped close to five Maternal and Child Health Care Facilities (MCHCFs): Saxaardid, Iftin, Abdi Eden, Mohammed Moge, and Sheikh Noor in Hargeisa, the capital of the self-declared independent state of Somaliland. The study received ethical approval from the Somaliland Health Research Ethical Clearance Committee and the LSTM Research Ethics Committee, and all participants provided written consent.

The study included TBAs practicing in the area and known to the healthcare providers at five MCHCFs surrounding Hargeisa, mothers from the community who had received care from the TBA, healthcare providers at the MCHCF, and key stakeholders from the government (Fig. 1).

During the program, TBAs were trained as "health promoters" and "birth companions" (Fig. 2), and linked to an identified MCHCF. Training included an emphasis on the need for prenatal care, understanding the dangers of a home birth, the benefits of facility delivery and a professional trained SBA, the need for prompt referral of all pregnant women to an MCHCF for care, the importance of companionship, and how to help women who were afraid of a facility-based birth or of complications. In addition, the TBAs visited the MCHCF, were oriented in the services provided at the facility level, and were introduced to the staff working there as SBAs. Refresher training was provided 1 year after the initial training.

The TBAs were paid US $5 for each patient referred or escorted to any of the five designated MCHCFs and were informed that the payment was temporary and would cease at the end of the implementation program. Fourteen months after the program had ceased and payments had been discontinued, TBAs were interviewed. Records of the women either accompanied or referred to an MCHCF were kept and compiled monthly by the program team.

All five MCHCFs and one referral hospital in Hargeisa were supported with infrastructure rehabilitation, supply of medical equipment, drugs and consumables, running costs, and competency-based training for healthcare providers in skilled birth attendance and emergency obstetric and newborn care [15]. In addition, the hospital's ambulance was provided for referral from the MCHCF to the hospital if indicated.

A qualitative approach based on focus group discussions (FGDs) and key informant interviews (KIIs) was used. The authors developed FGD and KII guides, participant information sheets, consent forms, and translator agreements. Local research assistants were trained on how to use the guides and conduct FGDs and KIIs before field work commenced. All FGDs and KIIs were conducted in a quiet, comfortable venue with adequate space.

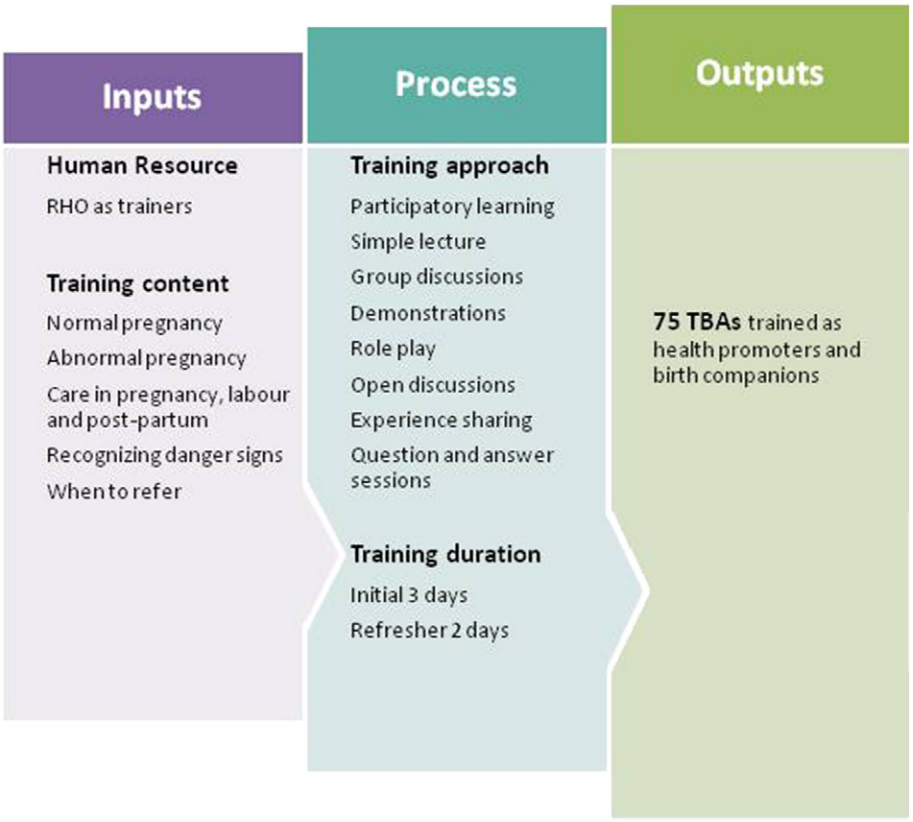

Fig. 1. Training provided to traditional birth attendants in Somaliland. Abbreviations: RHO, Regional Health Office; TBA, traditional birth attendant.