Factors And Challenges Influencing Mothers’ Choice Of Birth Attendance In Bunyala Sub-County, Kenya

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Abstract: Despite investments made in maternal health in the developing world, and a free maternal health programme being launched in Kenya, maternal and neo-natal deaths in Bunyala Sub county remain high. This paper is based on a study which sought to determine the factors Influencing Mothers’ Choice of Birth attendance in Bunyala Sub-County, Kenya. This included an examination of the challenges they face in trying to access facility-based maternity services. A sample of 385 mothers living in different locations of the sub county were surveyed, using a structured questionnaire. Health personnel in the main health facility in each location were also interviewed, and focus group discussions held with Community Health Workers and Traditional Birth Attendants separately. Data revealed that the mothers of Bunyala sub county generally prefer the government facilities over the TBAs primarily due to availability of skilled staff, medicines and equipment. However, some mothers prefer the TBAs because of flexibility of payments, payments in kind, accessibility at odd hours, because of good relations, for cultural reasons,(to refrain from having male birth attendants), and for fear of the mandatory HIV testing done under the PMTCT program. The challenges faced were mainly the distance to the health facility, the in affordability of travel, the cost of medical drugs and supplies, poor roads, unavailability of night time ferry services, verbal abuse and negative attitudes from some skilled attendants, and long waiting hours.

Keywords: Accessibility Challenges. Influencing factors. Free Maternal Care. PAPM. Skilled Attendants. TBAs.

1 INTRODUCTION

While the world has made great efforts to enhance maternal health and safety during delivery, a proportion of deliveries are conducted by skilled birth attendants. UNFPA (1997) reported that only about 44% of births were conducted by skilled attendants, and, according to WHO (2005), of the estimated total of 536 000 maternal deaths worldwide in 2005, developing countries accounted for 99%. Slightly more than half of the maternal deaths (270 000) occurred in the sub-Saharan Africa region alone, followed by South Asia (188 000). Thus, sub-Saharan Africa and South Asia accounted for 86% of global maternal deaths. In low and middle-income countries many deliveries occur at home and without the assistance of trained attendants (Carlough & McCall, 2005). The Kenyan Government, outlawed the use of the traditional birth attendants with the assumption that they were responsible for high mortalities and morbidities of mothers and new born babies. However, despite being outlawed, there remains a sustained demand for births by the unskilled birth attendants, and as a result, a sustained high maternal rate. In 2013, the Kenyan government began an initiative to provide free maternal services to mothers, in the hope that more of the mothers would opt to have a facility-based birth in the hands of trained medical personnel. A survey done in 2010 revealed that, in Bunyala sub County of Busia County in Western Kenya, only 12% of eligible expectant mothers seek services at the health facilities (GOK, 2009).

Reports indicate that, out of 3892 mothers enrolled in the first antenatal care only 332 mothers delivered in the health facilities while the rest were lost to follow up in the year 2010 (ibid.). This paper is based on a study whose aim was to investigate the factors that influence Birth attendance seeking behavior of mothers in Bunyala sub county, as well as the challenges they face in trying to access skilled maternal care services in the health public facilities. The study focused on mothers between the ages of 15years and 49 years, living within Bunyala Sub county, who were expectant or had given birth from the time maternity services were declared to be free of charge.

2 LITERATURE REVIEW

Babalola and Fatusi, (2009) assert that Africa has the highest burden of maternal mortality in the world and sub-Saharan Africa is largely responsible for the dismal maternal death figure for the region, contributing approximately 98% of the maternal deaths for the region. Throughout history, traditional birth attendants have catered to the majority of deliveries in rural areas of developing countries. According to Bergström and Goodburn (2001), there is little doubt that they play a significant role when it comes to cultural competence, consolation, empathy and psychosocial support during pregnancy and labour, with important benefits for the mother and the newborn child. It is now estimated that 85% of developing countries have some form of TBA training to enable them provide better maternal health services, thereby reduce maternal mortality. In Malawi, it was found that inadequate access to and under-utilisation of quality Maternal Health Care (MHC) services were major reasons for poor health of the women in Malawi. (Katenga-kaunda, 2010). On their part, Aboagyel and Agyemang (2013), carried out a study on how organization and financing of maternal health services influence health-seeking behavior in Bosomtwe district, Ghana, thereby contributing in furthering the discussions on maternal health-seeking behavior and health outcomes from a health system perspective in sub-Saharan Africa. The scholars employed a purposeful sampling technique to

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select 16 women in the district for their study. Their work highlights that characteristics embedded in decentralization and provision of free maternal health care influence health-seeking behavior. Particularly, the use of antenatal care was found to have increased after the delivery exemption policy in Ghana. Labour and delivery are the shortest and most critical period during pregnancy and childbirth because most maternal deaths arise from complications during delivery. Even with the best possible antenatal care, it is established that delivery could be complicated and therefore skilled assistance is essential to safe delivery care. Although skilled birth attendance is a most important step during delivery that protects against maternal and neonatal mortalities, many births are still conducted in the homes by family members, relatives and traditional birth attendants. In many countries where home delivery is the norm, midwives are only available in health facilities. In many cultures home based birth attendants are respected members of their community, perform important cultural rituals and provide essential social support to women during delivery. Maimbolwa (2004) observed that many women prefer to seek the assistance of traditional midwives for various reasons. Statistics show that Kenya is ranked 21st in an index of the worst countries in which to be a mother. 1 in 300 Kenyan women died while giving birth. This is attributed to haemorrhage, sepsis, hypertension disorder, unsafe abortions, obstructed labour, and other direct causes. It is also reported that Traditional birth attendants practice several risky methods including external cephalic version (ECV) without knowing the contraindications; lack of antenatal referral when patients are anemic or suffering from antepartum hemorrhage; lack of referrals for prolonged labor; lack of sterility and asepsis; poor handling of the cord; and use of poorly chosen instruments during delivery. The delay of referrals gives hospitals only a minimal chance of saving both mother and child. (Maimbolwa, 2004) Major indirect contributors to maternal deaths are malaria, anaemia and HIV/AIDS. Their contribution is estimated to be 20%. (NCAPD, 2010). Esena and Sappor (2013) posit that many women do not seek skilled care due to cost of service, the distance to the health facility, and quality of care thereby bringing about a low coverage. In the view of Erganol et al. (2012), the trend towards using home based birth attendants is most apparent in rural areas, distanced from the care of doctors and midwives. Provision of adequate antenatal care is regarded as a cornerstone of maternal health care. The detection of high-risk pregnancies through antenatal care has been advocated as a good tool to reduce maternal mortality in developing countries. The scholars go on to reveal that a study conducted in Indonesia revealed Traditional Birth Attendants have no formal training and some are illiterate, but they are ubiquitous and accessible at all hours of the day and night, making them a popular option for many poor women. Every village has at least one, but most have several. Titaley, Hunter , Dibley and Heywood (2010) opine that, because traditional birth attendants are from the village, they understand the traditions, cultures, and languages of the women that they attend to, an obvious advantage during antenatal care and childbirth. They learn from their mothers or older women in the village, and therefore their practice is fraught with risks for the woman and newborn. However, in many places, they deliver more babies than the skilled midwives. The village pregnant women and their families tend to trust traditional birth attendants and rely on their opinion. Titaley, et al (2010) deduced from a study they carried out in west Java, that distance and financial limitations were two major constraints that prevented community members from accessing and using trained attendants and institutional deliveries. A number of respondents reported that trained delivery attendants or an institutional delivery were only aimed at women who experienced obstetric complications. The Kenya Demographic and Health Survey, 2008-2009 records that, overall, only 44% of births in Kenya are delivered under the supervision of a skilled birth attendant, well below the target of 90% of deliveries by 2015. Traditional birth attendants continue to assist with 28% of births, relatives and friends with 21%, and in 7% of births, mothers receive no assistance at all (Calverton and Maryland, 2010). Bourbonnais (2013) argues that the problem of Kenya’s high maternal mortality and morbidity is driven, at least in part, by lack of access to quality maternal health services, including ante-natal, delivery, and post-natal services. The author goes on to assert that, although health sector infrastructure has grown over the past decade, many women still live at a considerable distance from health facilities, cannot afford to pay fees for maternal services, and/or face other barriers to accessing quality care (Bourbonnais, 2013). Access to skilled delivery is a particular challenge. Many women do not access the care they need for different reasons including low quality and availability, prohibitive costs, transport, and household decision making. One of the theories undergirding the study upon which this paper is based is the Precaution Adoption Process Model (PAPM). It is found in the category of Explanatory Behaviour change theories which seek to describe the reasons why a problem exists. The PAPM attempts to explain how a person comes to decisions to take action and how he or she translates that decision into action. Adoption of a new precaution (such as opting for facility-based birth attendance) or cessation of a risky behavior (such as desisting from TBA assisted delivery) requires deliberate steps unlikely to occur outside of conscious awareness. Although several aspects of the Precaution Adoption Process Model were first discussed in 1988 (Weinstein, 1988), the present formulation, published in 1992 (Weinstein and Sandman, 1992), differs in some respects from the initial version. The current PAPM identifies seven stages along the path from lack of awareness to action. At some initial point in time, people are unaware of the health issue (Stage 1). For example, expectant mothers may not be aware of the dangers of opting for home based birth services. When they first learn something about the issue, they are no longer unaware, but they are not yet engaged by it either (Stage 2). In the present example, a mother may become aware of the dangers, but may still not be ready to make a decision on whether or not to modify their behavior and opt for facility-based maternity services. In the PAPM Model, people who reach the decision-making stage (Stage 3) have become engaged by the issue and are considering their response. This decision-making process can result in one of three outcomes: They may suspend judgment, remaining in Stage 3 for the moment. They may decide to take no action, moving to Stage 4 (in our example, refusing to opt for a
facility-based birth experience) and thereby halt the precaution adoption process, at least for the time being. Or, they may decide to adopt the precaution, moving to Stage 5. For those who decide to adopt the precaution, the next step is to initiate the behavior (Stage 6). In the present example, this is the stage where the expectant mother opts to give birth in hospital as opposed to at home or in the care of a TBA. In the seventh stage, the behavior is maintained, meaning, for instance, the mother hereafter seeks out the services of a facility with skilled attendants to give birth for future pregnancies. The model is illustrated in Figure 2.1

![Figure 1: Weinstein and Sandman’s (1992) Stages of the Precaution Adoption Model Process](image)

The model contributed to the study’s framework by underscoring the importance of personal perception and attitudes which affect behavior. If, for instance, an expectant mother does not deem a TBA-assisted birth as being dangerous (or a facility-based birth as being very essential to her health and survival), she may not make the decision to use the skilled attendants, even if the service offered is free of charge. For behavioural change to occur, the expectant mother needs to go through the psychological stages described by the PAPM model.

3 METHODOLOGY

The study design (as guided by Kothari, 2004), was cross sectional survey, where the main unit of observation was the household where a woman was pregnant or had given birth in the last one year, and the unit of analysis was the woman herself. The study population also included Key Informants who were drawn from among the public health facility maternity service providers, Traditional Birth Attendants and Community Health workers affiliated to the health centres. These key informants primarily provided insights into the trend of birth seeking behaviour of the women in the study area, from the time they were declared free of charge by the current government, and for the period prior. The informants also provided information on the maternity services available in Bunyala sub county. The sample size was determined using the Fisher et al. (2003) formula, as quoted by Mugenda and Mugenda (1999), which is used where the population (N) is known to be greater than 10,000. It yielded a minimum sample size of 384 mothers, and one extra was added to satisfy the sampling requirements for the study.

The formula is:

\[ n = \frac{z^2 pq}{d^2} \]

Equation 1: Fisher et al. (2003) for Sample Size Determination

Where:

- \( n \) = the desired sample size by probabilistic sampling when the population is more than 10,000
- \( z \) = the standard normal deviate at the required confidence level i.e 1.96
- \( p \) = the proportion in the target population estimated to have the characteristic being measured i.e 0.5 (which is 50%)
- \( q \) = 1 - \( p \) i.e 0.5
- \( d \) = the level of statistical significance set

Mixed sampling techniques (both probability and non probability) were employed to arrive at the actual women interviewed for the study; this began with cluster sampling, where the study area was grouped into clusters which coincide with the five administrative locations of the sub county, preceded to non proportional quota sampling where, of the 385 respondents included, 77 were selected from each of the 5 clusters, and finally ending in a randomizing technique to identify households where a mother was pregnant, or had given birth within the last two years. Data was collected from both primary and secondary sources. Reliability testing was done to calculate the correlation coefficient that demonstrates the consistency with which the tools yield the required data. All necessary ethical considerations were observed; a research permit was obtained; the participants were treated with due respect, after giving their informed consent.

4 RESULT

Descriptive statistics (percentage frequencies) were used to compute and present the quantitative data. It was found that a number of negative pregnancy outcomes have been associated with the services of Traditional Birth Attendants, leading to more mothers patronizing the government services. Fourteen percent of the mothers in the study had ever suffered a miscarriage, 13% of them at the hands of TBAs; 6% of the mothers had lost a newborn, 5.2% having been at the hands of TBAs. Qualitative data revealed that mothers in Bunyala sub county had endured maternal deaths during childbirth as a result of hemorrhage, sepsis, pre eclampsia and eclampsia, and obstructed labour. All these arising the risky practices of TBAs, such as a lack of antenatal referral; lack of sterility; poor handling of the cord; and use of poorly chosen instruments during delivery. It was also seen that 84% of the mothers in the study mentioned the government facility as their preferred antenatal care provider, 82% claiming that the services government facilities, the study established that the mothers of Bunyala sub county generally prefer the government facilities over the TBAs primarily due to availability of skilled staff, medicines and equipment. It was also seen how some mothers prefer the TBAs because of flexibility of payments, payments in kind, accessibility at odd hours, and good relations (some are relatives). Others (21%), for cultural reasons, refrain from having male birth attendants, while others shy away from government facilities for fear of the mandatory HIV testing done under the PMTCT program. When interviewed, the health center staff mentioned a number of factors that challenge the provision of the free maternity services. The most frequently cited was staffing.
They felt there were not enough skilled personnel to serve the sub county, resulting in over worked staff. They also faulted the lengthy tendering process to acquire drugs and supplies that sometimes results in a time lag of up to two months before drugs are acquired for the facility. According to the Clinician at the sub county hospital in Port Victoria, the challenges they are facing are as a result of the teething pains of devolution in the health sector. The key informant asserted that the staff had not taken devolution positively, and were therefore demoralized. Many are quitting for other jobs in NGOS and private hospitals. One stated, “The staffs feel underpaid because the county government has been unable to sustain the recommended salary raises.” Health Centre In/Charge

When asked if there had been any friction created between communities and health staff and between facility managers and higher levels of the health system, as a result of challenges in implementing the free maternity services, most health centre key informants responded in the affirmative. One of them stated, “Yes. The staffs we have were hired 3yrs ago on the ESP (economic stimulus program). When their contract expired they were supposed to be absorbed by the government. But there has been delay and we don’t know what problem is. Some staffs in other facilities have given up and left.” The study found that mothers faced a number of obstacles in accessing skilled maternal care services in Bunyala sub-county. The first was the distance the mother has to travel to the nearest birth attendant, where it was seen that, for 56% of the mothers, the distance to the health facility was reported to be far, added to this, 50% of the mothers travel by motorcycle, and for more than half of the mothers in the study (53%), the cost of transportation was not affordable. Another challenge discussed was the availability of medical drugs and supplies, and it was seen that in general the mothers are required to pay out between ksh320/= and ksh 500/=.

Regarding the attitude of birthing attendant, 88% of mothers reported the attitude of the skilled attendant as being hostile, and when asked about the attitudes of TBAs, 30% of mothers said that they definitely provide more psychological support than the skilled attendants. The study learned from 45% of the mothers that the verbal abuse is indeed one of the reasons some mothers shy away from using government services. Similarly, it was seen that, with regard to the influence of language and communication, the traditional birth attendant’s ability to communicate with the mother in the local vernacular is the reason some mothers prefer their services. Regarding the availability of night services, it was not much of a challenge as only 10% of the mothers reported not having birth attendance services availed to them at night, and 16% of the mothers believed that institutional delivery is only for mothers with obstetric complications. Regarding the adequacy of skilled and trained personnel at the government facility, it was seen how, in the opinion of the clinical officer, the current staff is not adequate to provide services. The study was informed through key informants, that equipment was a challenge in most of the health centre, yet half of the respondents (50%) reported that their centre had equipment. It was also seen how some of the mothers still fear the stigma of HIV testing that is part of the PMTCT government maternity service, as well as the added challenge of the poor road network in the south across the river. The chapter discussed how husbands as birth partners sometimes fail to cooperate or take up their responsibility for birth preparedness, how at other times there is a lack of medicine in the health centres which puts a strain on the couples whose income is usually below average.

Plate 1: Mothers waiting to be Attended to at the Budalangi Health Unit
Source: Field Data, Busia County, 2015

Reflecting upon the results with the PAP Model in mind, one could infer that the decision to use either one or another birth attendant service represents the 4th to 7th stages in the Precaution Adoption Process Model. By deciding to take no action towards using skilled birth attendants in facilities, the Bunyala sub county mothers halt the precaution adoption process, at least for the time being. Those who decide to adopt the precaution (using skilled attendants in the facilities), effectively move to Stage 5. Those making such a decision, move to the next stage of initiating the behavior (of giving birth in a health facility). In the seventh stage, the behavior is maintained, meaning the mother hereafter seeks out the services of a facility with skilled attendants to give birth for future pregnancies.

5 CONCLUSION

Based on the results above it is concluded that the factors influencing the mothers’ choice of birth attendance emanate from negative outcomes for those attended to by TBAs; the economic, psychological and physical access advantages offered by the TBA option; and the accessibility challenges faced in trying to access skilled birth attendance. The negative outcomes from use of TBA services include miscarriages, loss of newborns, maternal deaths during childbirth from hemorrhage, sepsis, pre eclampsia and eclampsia, and obstructed labour. These outcomes result from risky practices one the part of these TBAs, such as lack of antenatal referral, lack of sterility, poor handling of the cord, and use of poorly chosen instruments during delivery. However, the advantages of the TBA option enticing some mothers include flexibility of payments, payments in kind, accessibility at odd hours, the TBAs ability to communicate in the local vernacular, their kind, empathetic disposition, and cultural taboos. For some mothers it is to avoid HIV testing under the PMTCT program. Mothers seeking facility-based services face a number of accessibility challenges; there are physical
access challenges where the distance to the health facility, poor roads, the expense of travel, and the absence of ferry services (for those living on the other side of the river) collude to prevent mothers reaching the health facility closest to them. The economic access is barred by the cost of medical drugs and supplies, while the psychological access for some is hindered by the negative, hostile attitude of some skilled attendants, the verbal abuse meted out to mothers in labour, and the general long waiting hours at each visit.

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7 REFERENCES