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Respectful maternal care and by who? perspectives of Somali community at IFO refugee Camp, Dadaab, Kenya

Abstract

Respectful maternity care is where women are accorded the freedom to make informed choices, protects them from any form of harm and harassment, provides continuous support during labour and child birth and also upholds their privacy, confidentiality and dignity. Previous studies have demonstrated that any care deemed to disrespect the woman may henceforth determine her care seeking behaviour. In the lacuna created by some forms of disrespect of women of child bearing age in the healthcare system, some women may seek alternative care from traditional birth attendants, who are neither skilled nor able to promptly recognize, manage or refer complications arising during pregnancy, labour, child birth and puerperium. Globally, the high maternal mortality rate is associated with preventable complications which occur during pregnancy, labour, child birth and the puerperium, with those who encounter near misses or who narrowly survive death, end up suffering lifelong disability which affects their quality of life. Services offered by traditional birth attendants (TBAs) continue to be sort by a few women of reproductive age in both rural and urban settings including Dadaab, despite the availability of both public and private health facilities. TBAs are preferred among the Somali community as they are deemed to offer a type of care that is regarded as being respectable to the woman and her family as well as being aligned to their culture and religion. Hence, this study aimed to investigate the perspectives of the Somali community residing in Dadaab refugee camps on respectful maternal care. A qualitative study was conducted at Ifo refugee camp in Dadaab, where three TBAs, two save mothers, two married men and two expectant women were interviewed. Two focused group discussions were conducted among the men and pregnant women. The TBAs and the save mothers were interviewed. The TBAs were also video recorded as they performed some of their activities. Data was coded, categorized into thematic areas and the content was analyzed. The findings demonstrated that TBAs and save mothers accorded the women both social and psychological support during pregnancy, child birth, and postnatal period, and treated them with respect. They accompanied the mother throughout the labour and childbirth and gave her so much encouragement. The findings further revealed that cultural beliefs and practices such as prayer, disposal of the placenta and the gender of the care provider, play a big role in maternal care of the women. The placenta is valued as a significant part of the woman's body and thus has to be buried according to their culture, as opposed to it being disposed of after giving birth in a health facility. Respectful maternal care should be accorded to all women irrespective of their background and should also be culturally sensitive.

Keywords: child birth, health facility, maternal care, traditional birth attendants, women, pregnancy, continuous labour support, respectful maternal care

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Introduction

One third of the global child birth events occur with the absence of skilled birth attendants (SBAs).[1] Majority of the births in low and middle-income countries are conducted outside health facilities by untrained birth attendants (BAs) posing a global health concern which contributes to poor maternal and neonatal outcomes.[2,3] For instance, in the Somali predominant Dadaab refugee complex health facility based births in 2015 ranged between 61 to 87%, indicating that there were still a number of women who were giving birth outside designated health care facilities despite these facilities being available.[4]

Globally, an estimated five hundred thousand women die annually due to complications arising during pregnancy, labour and childbirth and the postpartum period, with approximately half of those deaths occurring in Sub-Saharan Africa.[1,5,6] For instance, the maternal mortality ratio (MMR) in sub-Saharan Africa is 500/100,000 live births.[5,1] In Somalia the home country of the refugees, the MMR and neonatal mortality rates (NMR) of 732/100,000 live births and 38.8/1,000 live births respectively, are exceptionally high compared to Kenya's MMR of 510 per 100,000 live births according to the World Health Organization's trends of maternal mortality, and the sustainable development goal target of less than 70 per 100,000 live births by 2030.[4,7–9] These deaths have been attributed to poor uptake of skilled attendance at birth given that less than ten percent of these birth are conducted by SBA.[4] Effective care during childbirth and postpartum period under SBA, is a critical determinant of maternal and neonatal.[10,6]

WHO advocates for skilled attendance at birth as a critical strategy of averting maternal mortality, and defines a skilled birth attendant as "an accredited health professional such as a midwife, doctor, or nurse, who has been educated to proficiency in the skills needed to manage normal pregnancies, childbirth, and immediate postpartum period

and in the identification, management and referral of complications in women and newborns".[11,12] The International Confederation of Midwives (ICM) acknowledges a midwife as a responsible and accountable professional who supports a woman during pregnancy, childbirth and postpartum period, as well as conducting births and taking care of the newborns.[13]

SBAs play a critical role during pregnancy, childbirth and the postpartum period. During pregnancy for instance, the SBA performs comprehensive assessment of the woman and fetus, provides prophylaxis against malaria, tetanus, and hookworm infestation, assists the woman in developing and individualized birth plan, and counsels on health promotion and complication readiness. Throughout labour and childbirth, the SBA monitors the woman, fetus, and the progress of labour, diagnoses and manages complications, and provides both psychological and continuous labour support. In the postpartum period the SBA will diagnose and management any complications that may arise, counsel of exclusive breastfeeding, family planning, and immunization, and support the mother in breastfeeding.

Various studies have shown that women from both urban and rural settings, and especially those in marginalized and emergency settings continue to seek care during pregnancy, childbirth and postpartum period from the traditional birth attendants (TBAs) despite knowing the lurking dangers of being managed by unskilled BAs.[1,6] This choice seems to be partly influenced by the women's personal preferences although socio-cultural factors may play a role to a large extend. In Niger, only an estimated 17% of pregnant women give birth in a hospital setting under the assistance of SBAs, with the majority assisted by traditional birth attendants.[11] Nationally in Kenya, 62% of births are attended to SBAs, with 50% and 8% of births in rural areas and pastoral areas (Samburu and Laikipia), respectively, attended to SBAs.[6] This is clear depiction that a good number of births are conducted by persons who may not have the requisite knowledge and skills. However, an interesting observation was made in Niger whereby constructing more hospitals and employing more health care providers did not result in improved uptake of these services because culture had a big influence in leaning towards TBAs.[1]

Many reasons have been given for the preference for traditional birth attendants: limited resources for seeking childbirth services in hospitals, continued psychological support and empathy during childbirth, acceptability of TBAs in some cultures, TBAs being easily available, and inaccessibility of SBAs.[6,14] Mwoma et al.,[1] in their study identified several factors that contribute to women preferring TBAs. They include: TBAs being friendly to the mother; being familiar with the culture and tradition; they come in handy when needed and in the home of the delivering mother; accompany them to the hospital in case of a complication during delivery and when taking the baby for antenatal clinic among others.

Disrespect and abuse of women during childbirth continues to be a global phenomenon affecting the care women receive during pregnancy, child birth and the postpartum period, with its prevalence increasing over the years.[15,16] The current prevalence ranges from 20% in Kenya to 98% in Nigeria, and this has seen the WHO make a statement against to promote Respectful Maternity Care (RMC) and human rights during pregnancy and child birth.[15] Seven categories of disrespect and abuse have been identified: physical abuse (beating, slapping, or pinching), discrimination (based on culture, age or social status), non-consented clinical care, non-dignified care (yelling, chiding, undignified comments), non-confidential care, abandonment of care (leaving client unattended), and detention in health facilities.[9,15]

Respectful maternity care (RMC) as one that accords women the freedom to make informed choices, protects them from any form of harm and harassment, accords them continuous support during labour and child birth and also upholds their privacy, confidentiality and dignity.[5,16] This is echoed by Dzomeku et al.,[17] where RMC entails providing quality care that is not disrespectful, discriminating, dehumanizing, humiliating, and abusive; physical, psychological, or verbal. RMC emphasizes provision of high quality, evidence-based and informed care, while contextualizing it to the various needs of women and their newborns.[16] Disrespectful and abusive care is any interaction or condition that is experienced or intended to be humiliating or undignified, causing psychological or physical harm such as mistreatment, discrimination, unconsented care and failure to provide continuous labour support.[16,17] Disrespect and abuse may occur due to poor working conditions, excess workload, poor work relations with superiors, low staff numbers at different levels and absence of professional support for the health care providers.[15] According to Mwoma et al.,[1] SBAs are very few especially in rural and marginalized communities such as refugee camps. This disparity does not accord the personalized care that the women would require during that critical period. Any form of disrespect to childbearing women may hence have an impact as to where they seek maternal care.[18] Improving the quality and standards of respectful care may thus increase utilization of health facility care with prospects of better outcomes for women and their neonates.[15]

This paper seeks to explore the "respectful maternal care" as provided by TBAs to the Somali community residing in Dadaab, in a bid to tap their knowledge and enhance the skills in the training of midwives.

Methods

A qualitative preliminary survey was conducted at Ifo refugee camp in Dadaab, where a total of 9 participants comprising of 3 TBAs, 2 save mothers, 2 married men and 2 expectant women were included. Garissa County houses the Dadaab refugee complex which is comprised of 3 camps: Ifo, Hagadera, and Dagahaley refugee camps. Ifo and Dagahaley camps are located in Dadaab district also called Lagdera, while Hagadera is located in Fafi district. The camps are inhabited largely by the Somali refugees who have been fleeing their homeland since 1991 mainly due to civil unrest and famine.[4] Other camps: Ifo 2 and Kambioos which were opened in 2011 to serve the expanding population of refugees, have since been closed after the introduction of voluntary return programme which has seen some of the refugees returned back home.

Buy-in from the community members was achieved through holding the initial meeting with the gate-keepers at Ifo refugee camp. The researchers explained to them the nature and purpose of the research, and they were encouraged to express their honest feelings and opinion on the same. They were also given an opportunity to ask questions for clarification. Once they were satisfied with the answers and explanations provided, they gave a go ahead for the research to proceed.

Another meeting was held with the traditional birth attendants and the women to explain the purpose of the research in detail including their role in the research. They were also encouraged to ask questions which were answered explicitly by the research team. They were then separated into two groups: one for the TBAs and the other one for the women. A researcher went on to read the contents of the consent to each group of participants. It is only when they clearly understood, that

they were asked to sign the consent forms indicating that they were willing to participate in the research. Another session was held later in the day with the TBAs and the women where they were exposed to Virtual reality (VR) headsets and they were explained how their activities would be captured into such technology. During this session all the necessary COVID-19 containment measures were adhered to.

Data was collected through interviews, focused group discussions and Virtual reality (VR) recordings. Two focused group discussions were held with the men and women. The traditional birth attendants were interviewed and video recordings were also taken as they went about their activities of providing care to the women and also showing how they dispose the placenta following birth. Save mothers were also interviewed regarding the care they gave to the women. To cater for the language barrier, two research assistants were recruited to serve as translators. They translated the questions to Somali as they spoke to the respondents and relayed back the responses to the researchers in English. Data was coded, categorized into thematic areas and the content was analyzed.

Results

Demographic data of the respondents

Nine respondents were interviewed comprising of 3 TBAs, 2 pregnant mothers, 2 men and 2 refugee save mothers. The first male respondent was aged 35year old and came from the host community, while the second one was a refugee aged 60 years old residing in Ifo refugee camp. Each of the men was married to one wife. The first respondent who was a businessman had been married since 2016, had 5 children and was currently expecting a 6th one. He expected to wed his second wife in December 2020. The second respondent was a camp elder and was married to one wife. He had 5 children and was not considering marrying another wife in the near future. Both men had attained tertiary level of education.

The three TBAs interviewed where aged between 50 and 69 years old. Each TBA had children ranging from five to several. Two of them lived with their grandchildren from their daughters. It was noteworthy that the TBAs counted these grandchildren as their own children, and this explained the high number. It is only upon further probing that, they stated the number of children they had given birth to. Why this was so is not established, however, one would imagine that those grandchildren are counted as her own because she was the care giver.

The TBAs had offered their services to the community for a period of between 30 to 40 years, implying that they started practicing in their 20s. Given that on average they assisted in the birth of 4 to 5 babies per month, they therefore could only state that they had assisted several women to date. They were also proud to state that none of them had ever lost a mother or baby during the period of their practice. They neither had formal education nor other means of livelihood apart from the support they received from UNHCR and the small tokens they received here and there after helping women during pregnancy and childbirth.

Save mothers were younger women who had completed secondary school level education. They had undergone some informal training on some midwifery skills and were currently working as community volunteers attached to the Red Cross hospital. The two who were interviewed were aged 26 and 27 years old. The 27-year-old save mother was married with 2 children and was expecting her 3rd child. The other one was aged 26-year-old and was single with no child.

Two expectant refugee women were interviewed and only one consented to VR recordings. One was aged 30 years, while the other was 25 years old. They were both married with three children each, and coincidentally, they each were expecting their fourth child. Their husbands did not have other wives, as yet.

Why are TBAs preferred more than hospitals?

Upon asking why TBAs were preferred more than seeking hospital services, it emerged that childbirth among the Somali community was considered sacred and ordained by Allah. The TBAs were preferred and trusted because they were from the same community, they knew the women well, understood the culture, traditions and religious implications and also prayed with the women during childbirth. On the other hand, it was felt that if women went to hospital they would be treated as strangers because the health care providers did not know them, and they were also not conversant with their cultural practices and would thus not treat childbirth with the reverence it required. They treated pregnant women with respect and gave them advice on how to breast feed and take good care of the baby.

The men preferred the TBAs because they were from the same community and thus more trusted. One man said that it was cheaper for a woman to give birth under the care of the TBA because it reduced the cost of hiring for transport to the hospital. The woman would also be at home and thus oversee the care of the other children and the other activities. The TBA was with the woman throughout the process of giving birth therefore offering her continuous psychological support and also using non-pharmacological forms of pain relief such as telling stories to facilitate a natural birth. She was also experienced and kept the woman's secrets in confidence. He revealed this by saying that" The doctors have several women to attend to but TBA has quality time with our delivering wives".

The other man said that if the wife was being assisted by the TBA, he was allowed to see how she was fairing from time to time as opposed to if she was in hospital. This is because hospitals did not provide much privacy and the Somali culture considered it "Halamu" to see another man's woman in her nakedness. The two men also indicated that they did not want their women to be cared for by male health care providers who were the majority in the hospitals.

There was also a general misconception among the men that if their wives went to hospitals, the doctors would recommend caesarean section, which was considered as a form of death, and it would cripple the woman making her unable to discharge her duties and also predispose her to actual death. Following the surgery women are advised to avoid getting pregnant for at least two years and were thus put on contraceptives. One man detested this advice by saying:

"This is terrible because we need her to get another child as soon as possible. Worse, still we cannot have sex with her until after two years for fear of making her pregnant, which means we are forced to take another wife. "

On probing the man's response further, it emerged that the Somali culture was against use of contraception, and since the man was not able to have sex with his wife for fear of her falling pregnant with a raw scar, he would be forced to marry another wife. Taking another wife was also expensive because the man had to give four camels as dowry, which he may not have planned for. Moreover, the woman would be incapacitated, not able to engage in strenuous work, and she also had to make numerous visits to the hospital and this also came with a cost implication in terms of transport. Furthermore, if the woman knew that her husband would take on another wife, she would try to avoid caesarean section at all costs. It was also believed that the TBA had magical hands which facilitated the most difficult of the births. One of the men said:

"People here know and trust that TBA are way better than hospitals. The only thing doctors know is caesarian section, yet it is crippling and make our wives, daughters and sisters invalid and condemned. It is like a curse. It affects us men and our families too."

The pregnant women were asked why they preferred the TBAs more than hospital. One of the respondents a 25-year-old woman indicated that the TBAs were considered as one of them and they trusted them. The woman was captured saying: "The TBAs are good and trusted, they have time for us, use our language which we understand and they are our sisters".

The 30-year-old woman had delivered all her three children in hospital and she said she would be delivering the 4th one under a TBA. She said that: "TBAs are near home in the blocks". TBAs were interviewed on why their services were preferred more than those at hospitals. The 54-year-old TBA indicated that: "Nurses in hospital are rude, abusive and hostile to delivering mothers. They are not kind and sometimes say very nasty things to a person who is already in pain which is very disheartening, demoralizing and unkind".

The 50-year-old TBA responded to the question by saying: "TBAs watch over the mother before delivery date and after. I bury the placenta within the mother's compound or in my compound if she delivers in my compound".

The 69-year-old TBA said that she was able to intercept even in complicated labour and child birth and save the mother from going for caesarean section. She believed that the umbilical cord was responsible for prolonged labour and through massaging the woman the complication would be resolved. On further probe about this, she gave a scenario where she had accompanied a woman experiencing a complicated labour to the hospital. Upon reaching there and after the review by the doctor, a decision was made for caesarean section. Once she was left with the woman, she massaged her and the baby came out. She qualified this by saying that: "The mothers believe my hands are blessed and if I massage them the baby will come out because I have blessed hands".

On further probe on what else made the women prefer TBA services, she responded by saying:

"It is near for the mother". I recite some part of the Quran and pray placing the Quran on the womb for the mother and baby's safety and to end the pain if the mother is sick. I bury the placenta far away from the house so that children cannot urinate on it. We help follow Somali custom of burying the placenta. I believe the placenta should be buried because I was taught by my mother never to give part of my body to the animals".

What care do the TBAs and safe mothers offer to women that is considered "respectful" to the community?

The 56-year-old man said that TBAs offered psychological support to the women. He qualified this by saying: "The offer social and psychological support such as massaging and patting the back of the delivering mother. They encourage the mother through giving encouraging stories and singing where sometimes women gather to encourage her to reduce anxiety. They encourage her that birth is a normal process".

The 30-year-old respondent said that TBAs use kind language. She narrated an incident where she had been taken to hospital during change of shift when the nurses were handing over and the language the nurses used on her felt offensive and she felt insulted. She also narrated an incident that had occurred during the birth of her 3rd child. The nurse attending to her had left her and when the urge to push came she pushed the baby out and it fell to the floor. It was at that point that she vowed that despite having been delivered of two other healthy babies in hospital, she would never go to hospital again to give birth.

The second respondent a 25-year-old woman said that she felt comfortable in delivering at home: "I have enough space here, in hospital you are restricted to your bed". She said that the TBA was always available when she needed her and she would be by her side supporting her during child birth and the period thereafter. She revealed this by saying: "Also my friend the TBA lives in our neighborhood, I don't have to get out of my compound, she will come when I call her and will be with me until I deliver, she will also take care of us thereafter. These are services I can't get that in hospital".

The use of herbs was generally accepted in the Somali community and the woman indicated that she had her herbs with her which she used whenever she needed them. She also indicated that use of herbs was not permitted within the hospital by saying: "I understand one is never allowed to carry these herbs to hospital". Virgin coconut oil to massage during the pregnancy".

She also indicated that TBAs used a language they understood, were more polite and kept encouraging. She also shared stories she had heard about the care in the hospital: "I hear in hospitals women are abused and every small complication they recommend caesarian which I think is the worst thing and I have vowed to avoid". She also spoke about the hospital environment which felt strange and unfriendly by saying:

"It is crowded. It is strange. I can't carry my herbs. I don't know the nurses or the doctors. I can't carry my children in order to care for them there. I have to leave my home and space behind. The environment is not friendly and nurses are not nice but abusive to mothers. The doctors/ nurses have no time for you until when the child is coming out… yet l am used to have someone around me all the time".

Moreover, the respondent supported the care offered by the TBAs by saying that they rarely lost their clients to child birth related complications. "In hospital we hear of deaths of women who died while giving birth".

The management of the placenta following childbirth was also raised by the woman because the TBA played a significant role. She asked: "Where do I bury my placenta? Who will bury it?

The TBAs were also interviewed regarding the care they offered to the women. One of the TBAs a 54-year-old woman said that she stayed with the woman throughout the birth process, offering her psychological support, encouraging her that birth was a natural process and even prayed for her. She also said she used herbs to massage the woman. She qualified this by giving the activities the TBAs engage in as they care for the women.

"We are always available during pregnancy, delivery and after delivery we stay with the mother and baby. We adhere to our culture, custom and religion when delivering the baby. We burry the placenta. We use the herbs which are an important part of the process and are recommended by Mohamed e.g. Black seed oil. We treat delivering mothers with a lot of dignity. We encourage and support the mothers even when they go to hospital. We work 24/7 day and night time … we offer our services.

On further probing about the herbs and their uses, she said: "Virgin Coconut oil is used for massaging the tummy and the back. Black seed oil is used to massage the pelvic muscles to help in opening the way". The 60-year-old TBA described the care TBAs offered to women who were in labour. She said that:

"I go to mothers home and help them deliver there, bury the placenta in the compound and pray for the new born baby. From 6-9 months when the mother develops pain the TBA massages the mother. If the fetus is in a bad position during delivery she uses coconut or Herbe Suda oil to massage the fetus until it turns to the birth canal".

The save mothers were also interviewed regarding the care they gave to the women. They explained that they had received some training from the Red Cross hospital and they worked there as volunteers. They hoped that they could be employed there as midwives. The 27-year-old save mother responded by saying: "I deliver the mothers who come to hospital to deliver. I give them treatment after they deliver and give them advice to breastfeed. We teach mothers how to hold a baby while breastfeeding".

The 26-year-old save mother said that they had been trained to assist in getting the woman to hospital when emergencies occurred at home. She also said that in the event the woman was also delivering, she would first assist her then call an ambulance and accompany her to hospital for further monitoring and recording of the birth. On further probing on exactly the role played by save mothers during pregnancy, child birth and the postpartum period, the 27 year old one elaborated by saying:

"We assist the mother to go to health post to get the clinic book where all her history and health condition is written, then she visits the clinic once every month and her condition and that of the foetus are checked. When she gets to the final stage of pregnancy, she is transferred to the main hospital in readiness for delivery. During labour, she comes to the hospital, that is where I help her deliver her baby and after delivery we give the mother pain killers, and Amoxil in case of infections. If the baby is ok and doesn't have complications we advise the mother to breastfeed the baby for at least six months".

The 26-year-old save mother said that they escorted women to hospital, advised them about the pregnancy. They advised them to take the medications that had been prescribed to them at the hospital. They also dispelled beliefs and myths regarding the potential for the medications to cause the women to have big fetuses and thus complicated births.

The 27-year-old save mother said that when an emergency arose in the hospital and a decision was made for the caesarean section, they explained to the woman and relatives why it had to be done. Such a decision was always met with resistance from and when the woman finally signed the consent, it would be already too late and by that time the fetus may have died. On further probing on exactly what role she played during that difficult period, she had this to say:

"I make her relax, then I take her vitals e.g. blood pressure, then I encourage her by telling her that I'm here to help you, and to make sure you are comfortable. I also tell her to relax and when the pains labour come she will push".

She also explained to the women what to do in the event that the emergency occurred while the woman was at home. "I tell her to take a taxi and remember to carry the clinic book come to hospital". In case she was at home and was called during an emergency, she had this to say: "If I'm home I call an ambulance and I accompany her to hospital immediately".

Upon asking whether they preferred assisting with childbirth at the home setting as opposed to the hospital, she responded that: "No, we can't because we don't have any delivering kit at home they are in hospital. However, when one ask for assistance we improvise by making a home delivery kit such as a razor blade. She was asked how they assisted the women who declined to be assisted by male doctors. She responded that: "It is unfortunate because mostly we have male doctors, females are nurses and can't help the patients as doctor's work. So as nurses we try the best we can to help. Only when we are defeated we call the male doctor".

She was further asked whether they worked together with the TBAs in providing care to the women. She said that:

"Yes I do, sometimes they ask me to check how far the woman is dilated, if I advise her to go to hospital and she refuses, me together with the TBA help her to deliver at home. If a woman has refused to go to hospital we call the TBAs and my friend we help her deliver at home. We also train TBAs by asking them to come for training in hospitals where they are trained by nurses. We use the normal delivery room to show case to the TBAs how a delivery is done, but we don't have training manuals".

Discussion

Respectful maternity is a rights based approach to a woman destined to accord her quality care. This section discusses findings under the following subtitles; continuous labour support, freedom to make informed choices, protection from harm and harassment, confidentiality privacy and dignity

Continuous labour support

It is apparent from findings that continuous labour support was an important aspect of childbirth among the Somali community. The TBA visited the woman during pregnancy, was with the woman during labour and birth and continued making visits and giving advice during the postpartum period. She lived within the camp, thus being very accessible, and also provided psychological support. Studies support a companion of the woman's choice for an improved childbirth experience, as depicted by Mwoma et al.,[1] who observed that refugee women found TBAs readily available and very supportive, as they were with the woman throughout labour and delivery and kept on encouraging her. The findings are also consistent with Bohren et al.,[19] whose findings from a systematic review revealed that continuous labour support was associated with improved birth outcomes.

Findings also indicate that men wanted to support their wives during child birth, but the limited space in hospital did not afford them the convenience to do so. At home, the husband was able to be with his wife and to keep checking on her from time to time. This finding agrees with those of Adatara et al.,[20] who found that the TBA allowed the family members to offer support to the woman during child birth. Having a birth companion is one of the interventions which supports respectful maternity care.[21] Moreover, a birth companion provides a safe and secure environment, advocates for the client's care, promotes improved communication between healthcare provider and woman, prevents medicalization of childbirth and shortens duration of birth.[21]

To reduce maternal mortality, it cannot be understated that women should deliver under the care of a skilled birth attendant. Whereas, shortage of qualified midwives has been cited as one of the reasons that women seek TBA services, having adequate numbers of SBAs will thus accord the personalized quality care that women desire. This study revealed that TBAs lacked skills in handling complications.

This finding is supported by Ameyaw & Dickson[11] and WHO,[12] in their definition of a skilled birth attendant. Obstetric complications contribute to maternal and neonatal morbidity and mortality. Women should also be allowed birth companions of their choice as supported by.[21]

Freedom to make informed choices

Women should have the autonomy to make informed choices. This gives them a right to self-determination. They should be provided with all the necessary information to enable them come up with the best possible decisions regarding their care. In this study, the influence of religion and culture stood out. All respondents alluded to the influence of religion, cultural beliefs and practices. Childbirth was considered sacred and sanctioned by Allah, with reciting the Quran and praying to Allah incorporated into the childbirth experience. This finding is similar to that of Mwoma et al.,[1] where the TBAs prayed for the baby and the woman before and after childbirth. Culture-sensitive care is vital as supported by the Constitution of Kenya where an individual has a right to opinion, belief, religion and conscience.[22] The woman's birth companion of choice is central in facilitating prayers.

Study findings reveal the cultural significance of the placenta and the role the TBA plays. She disposes the placenta according to what culture dictates. Majority of the respondents indicated that the TBA buried the placenta because it was considered sacred. These findings are in agreement with Nagahori & Vodounon[23] who found that the placenta was revered among the tribes who practiced farming in Benin, where the placenta was buried in the compound. Similar findings by Mwoma et al.,[1] and Adatara et al.,[20] also support the burial of the placenta when the woman delivers at home. However, the findings also depart from findings by Nagahori & Vodounon,[23] who found that the nomad tribe, Peulh threw the placenta away. The Constitution of Kenya stipulates that every person has the right to participate in his/her cultural life.[22] On the contrary, study findings by Reeve et al.,[6] did not reveal any cultural significance of the placenta among women from Samburu and Laikipia regions, as its disposal was not captured.

Use of herbs is a common practice among the Somali. The TBAs performed back and abdominal massages using herbs, during pregnancy and childbirth to promote relief from pain. These findings are consistent with those of Mwoma et al.,[1] where the TBAs used virgin coconut oil to massage the abdomen, and black seed oil (Herbe suda), to massage the pelvic muscles in preparation for childbirth. Study findings revealed that TBAs used abdominal massage to help the baby to turn. Medically, this equates to performing external cephalic version to correct a malpresentation. This practice may have detrimental effects such as triggering placenta abruptio and thus predisposing the woman to antepartum haemorrhage. Marshal & Raynor[24] advise that if this procedure is to be performed, it should be by a skilled birth attendant in the confines of a well-equipped setting with a stand-by theatre facility. On the contrary, Reeve et al.,[6] found that TBAs massaged the abdomen of the woman after childbirth to facilitate delivery of the placenta, if expectant management failed.

Findings indicate that Somali men are against use of conventional contraceptives especially when their wives undergo caesarean section and thus end up marrying other wives. There is generally a misconception about caesarean section which forces women to seek services of the TBAs in an endeavor of avoiding it at all costs. The process of getting the women to consent is also a challenge as revealed the study where the save mothers struggle to explain to the family why the surgery had to be performed. By the time the relatives or the woman give consent, it's usually too late. Emergency caesarean section is a life saving measure that is instituted by SBAs to manage obstetric emergencies. Study findings are contrary to Ameyaw et al.,[11] where it emerged that use of SBA is critical in preventing maternal and neonatal morbidity and mortality. These findings about decision making in certain aspects are almost similar to those by WHO,[5] who found that women from high income countries (HIC) were more likely to demand for their right to making decisions and also participating in their care, as opposed to those from low income countries (LIC).

Protection from harm and harassment

TBAs voiced challenges in caring for the cord, lack of equipment for carrying out a delivery and also lack of skills in handling complications. These practices are contrary to the provision of quality and safe health care and may indeed put the life of the woman, fetus or baby at risk and end up doing more harm than. Guidelines advocate for the use of chlorhexidine for cord care. Poor cord care may contribute to neonatal morbidity and mortality. It cannot be understated that obstetric complications contribute to maternal and neonatal morbidity and mortality, therefore WHO[12] advocates for child birth under a skilled birth attendance. TBAs are thus not SBAs. Moreover, WHO[25] makes a very strong statement that under no circumstances should women and newborns be subjected to harmful or unnecessary practices during labour, childbirth and the postnatal period.

Confidentiality, privacy and dignity

Confidentiality, privacy and dignity are critical ethical issues in nursing and midwifery. In this study it emerged that TBAs were from the same community, residing amongst them and thus were trusted because they also spoke the same language. They also treated the women with respect. Privacy is valued by the Somali community as well as any woman of child bearing age, as depicted by the findings where it was taboo for a Somali man to see another woman naked. Lack of privacy at the hospital made the men interviewed to choose to have their wives deliver at home under TBAs. This finding is consistent with Rosen et al.,[26] where majority of the maternity units in Zanzibar and Ethiopia, did not accord women privacy in the delivery room. Its taboo for men to see other women naked (Somali). Hence women prefer to deliver at home. Good communication fosters trust between the woman and care giver.

Conclusion and recommendations

Respectful maternity care provides women with preservation of their dignity, privacy, and confidentiality, right to make informed choices and to receive continuous labour support during childbirth, and should not be harmful nor harassing. While study findings reveal the role the TBAs play within the community in the Ifo Refugee camp, it cannot be understated that they are not skilled birth attendants with the requisite competencies as well as the resources to diagnose and manage obstetric complications. In a bid to improve birth outcomes among women, this study therefore recommends upscale of community outreaches/sensitization on skilled care during pregnancy, child birth, and postpartum period. Nurses/midwives should be sensitized on respectful maternity care**.** Further studies should be conducted on health outcomes of women and neonates among the women who received care from TBAs**.** There should be increased funding into training, employment and deployment of more midwives to the health care facilities that serve the refugee population. Training should focus on sponsoring training of midwives from Dadaab and host communities and deploying them back there after completion**.** Infrastructural modifications should be made in the health care settings to afford privacy and thus increase male participation during child birth.

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Conflicts of interest

We wish to declare that we have no conflict of interest.

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