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Awareness of cultural practices by skilled birth attendants during pregnancy and birth in Kenya: An interpretive phenomenological study

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ABSTRACT

Cultural capacity among SBAs is recommended in maternal care to promote culturally safe care and meet the childbearing women's cultural needs and expectations. This study aimed to explore awareness of cultural practices by skilled birth during pregnancy and birth within the Keiyo community in Kenya.

Methods: A qualitative phenomenological study was conducted between August to December 2019. A semi-structured interview guide was piloted with two SBAs. Individual interviews and data analysis were conducted iteratively. Eleven participants were interviewed, and saturation of themes was achieved after the ninth SBA. Audio recorded data were transcribed and analysed using ATLAS.ti Software version 8.4.4 (1135) that followed Van Manen's five steps of thematic analysis.

Findings: The three themes that emerged from an inductive and iterative data analysis process were SBAs familiarity with cultural practices, SBAs awareness of cultural practices, women's expectations of clinical care and challenges to establishing a more collaborative relationship between SBAs, traditional birth attendants (TBAs) and childbearing women.

Conclusion: The SBAs awareness of cultural practices was highlighted through relationships formed during care engagements. This awareness revealed a potential indicator for women's choice of caregiver. Awareness of threats to cultural safety and fear of disclosure potentially created mechanisms to promote more collaborative care. A broader scope of skilled care approaches requires heightening maternity care providers' cultural sensitisation to reduce gaps in women's cultural needs and expectations.

1. Introduction

Culture has continued to be inextricable with the childbearing journey. Cultural beliefs and practices influence women's childbearing decisions. Therefore, health care providers should strive to be aware of standard cultural practices within their environs (Withers et al., 2018) to provide culturally safe care (Ramsden, 1992).

Every day, 830 women die globally. Sub-Saharan African accounts for 546 per 100,000 live births and 66% globally (World Health Organization, 2018) According to Kenya Demographic Health Survey (KDHS) (Government of Kenya, 2014) Kenya records 362 maternal deaths per 100,000 live births, which are five times more than the target of 70 per 100,000 live births set for the Sustainable Development Goals (SDGs) by 2030 (World Health Organization, 2015).

According to World Health Organization (2018) and Say et al. (2014), deaths are commonly caused by haemorrhage, eclampsia, sepsis, obstructed labour, and unsafe abortion. Approximately 60–80% of these obstetric complications are preventable if pregnant women seek appropriate care early during pregnancy, labour, birth, and motherhood.

In Kenya, 95% of pregnant women attend antenatal care, but only 40% of them seek skilled birth care (KDHS, 2014) despite the government's efforts to improve access through better infrastructure, reduced user fees, and proximity of service delivery points. The government aims at providing universal health coverage and equitable services geared to foster positive outcomes (Ministry of Health, 2016; Okech & Lelegwe, 2015).

Kenya has 13 ethnic groups resulting in 44 tribes. There are 42 indigenous ethnic and two other Indian and European immigrant tribes. Each tribe's unique culture and history shape its rich, culturally diverse background (Kenya information guide, 2018; Kenya National Bureau of Statistics, 2020). This great diversity poses many challenges for health

Abbreviations: SBA, Skilled birth attendant.

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care systems and service providers in Kenya.

Cultural influence is one of the significant factors that cause the underutilisation of intrapartum services. The high utilisation of community services such as the traditional birth attendants and traditional healers, instead of the skilled birth attendants, highlights the existing provider preferences amongst women (Mander & Miller, 2016; Shiferaw & Modiba, 2020; Shrestha, Pradhan, Tran, Gualano, & Fisher, 2016).

Women embody cultural beliefs that aim to protect mothers and children during pregnancy and birth. Although, some of the beliefs may also discourage women from accessing health care, thus negatively influencing maternal, neonatal, and child outcomes (Munabi-Babigumira et al., 2017).

The TBAs still provide their services in the Keiyo community. There is no formal collaboration between them and the SBAs. Reeve et al. (2016) and Anono et al., (2018) indicate that informal linkage is when TBAs are encouraged to escort women to the health facility, check and remind the women to go for clinic follow up and act as a cultural link between the women and the SBAs.

The Keiyo rural community still observe their cultural traditions. The TBAs, older women relatives, or community members propagate these practices and beliefs to flourish and safeguard the practices. Riang'a et al. (2017) confirm that cultural practices are specific to every childbearing continuum aspect. Practices include food restrictions and recommendations, sexual activity restrictions, interpersonal relations, language, herbal remedies, roles and responsibility prescription, dressing, ceremonies, and utilisation of TBAs' services.

Culture is part of holistic human identity. The heightened awareness of social justice, such as human rights in health care and a person's cultural identity aspect, are considered essential and should not be ignored (Erdman, 2017; Perkins et al., 2019). Therefore, the health care provider should appreciate these views while providing health care services to women and their families.

Respect for culture, traditions and taboos is recommended in the maternal and child health guidelines drawn up by the United Nations (World Health Organization, 2018) and International Confederation of Midwives (International confederation of midwives, 2019). Implementation of these guidelines is aimed at the technical quality of care and ensuring satisfaction with care amongst women, babies, and families with their particular and different socio-cultural backgrounds (International confederation of midwives, 2019).

However, adequate emphasis is lacking in incorporating cultural aspects into the delivery of individualised care, despite evidence that this is useful (Munabi-Babigumira et al., 2017). Therefore, cultural awareness among the SBAs is achieved through sensitisation training to bring individuals to at least a superficial realisation of existing cultural differences between themselves and others, not of an emotional, economic, or political nature (Ramsden, 1992).

According to Ramsden (2002), increasing cultural awareness among skilled birth attendants (SBAs) will enable a culturally safe environment for women and their families during the childbearing period. This awareness will address the challenges facing the SBAs in Kenya due to the many diverse ethnic groups. Paying attention to the diversity of cultural beliefs and practices in the local population and staying up to date with dynamic clinical practice is challenging for the SBAs. Therefore, Munabi-Babigumira et al. (2017) and Hulsbergen and van der Kwaak (2020) recommend collaboration and teamwork between care providers and building therapeutic relationships with care recipients.

The inadequate and or lack of cultural capacity of SBAs influences the satisfaction of childbearing women. According to King and Jones (2019), some of the key factors that deter women's engagement with SBAs are the lack of culturally congruent care provision to women during pregnancy and birth. Further, this lack of privacy and culturally congruent care becomes a barrier to women's access.

Adatara, Strumpher, Ricks, and Mwini-Nyaledzigbor, (2019) allude to the sensitivity of SBAs to cultural practices, but no literature was found that explores the awareness of cultural practices by the SBAs.

This study aimed at exploring awareness of cultural practices by SBAs during pregnancy and birth in the Keiyo community in Kenya to develop and implement appropriate strategies to improve the utilisation of skilled birth services.

2. Methods

2.1. Theoretical framework

The researcher utilised the cultural safety theoretical framework (Ramsden, 1992) Fig. 1.

Framework utilisation to navigate cultural awareness concepts enables openness (de Witt & Ploeg, 2006) related to SBAs' awareness of cultural practices across the childbearing continuum to be understood from an existing point of reference built from available evidence regarding cultural awareness.

Ramsden originally developed the framework to address the inequalities experienced by the indigenous people of New Zealand in the recruitment and retention of Maori nursing students and the negative experience of Maori people while seeking health care services (Papps and Ramsden, 1996). Contextualisation of the framework helped explore awareness of cultural practices by the SBAs in the local Keiyo community to get information regarding childbearing women's cultural safety during clinical care.

Cultural safety "relates to the experience of the recipient of care and extends beyond cultural awareness, and cultural sensitivity of the health care providers" (Ramsden, 1992). "On the contrary, culturally unsafe care is considered to be any action or omission which endangers the wellbeing, demeans the person or disempowers the cultural identity of the patient/client". Culturally safe care is dependent on health care providers who have undergone an initial stage of cultural awareness that progresses to cultural sensitivity (Nursing Council of New Zealand, 2011).

To achieve cultural safety, health care providers need to undergo a transformational change that begins with cultural awareness achieved through sensitisation to the existing differences between self and others. This realisation needs to activate cultural sensitivity. The characteristics of the individual professional have displayed the actions that will show that the individual is sensitive to another individual's cultural needs (Brooks, Manias, & Bloomer, 2019).

On the other hand, an organisation can be culturally sensitive by ensuring its operations are consistent with the community they serve through policies and other relevant structures (McCalman, Jongen and Bainbridge, 2017). Therefore, the SBA will have to fulfil these stages to be a culturally safe provider.

The study contextualised cultural awareness through in-depth interviews to elicit information that depicted SBAs' realisation of existence or the absence of cultural difference between them and the women they engage with during clinical practice. The author adopted a stepwise approach to allow for a well-defined distinction between the steps (awareness and sensitivity), culminating in cultural safety as an outcome (Ramsden, 2002).

Cultural awareness is the first in a series of articles. The studyfocused on the cultural awareness concept, the initial step of the cultural safety framework. This initial stage engages the individual SBA to be more aware of their own beliefs and assumptions, power differences and diversity. And to also realise that a lack of awareness can manifest as judgement or prejudice during their engagement with people from different backgrounds (Nursing Council of New Zealand, 2011; Ramsden, 1992, 2002).

The subsequent article will explore birth attendants (TBAs and SBAs) experiences with cultural sensitivity to cultural practices during the childbearing period. Sensitivity is the second step of the cultural safety framework. The outcome for both steps will set the stage for the final stage of the study, which explores women's culturally lived experiences to explore culturally safe care, an outcome of cultural awareness and

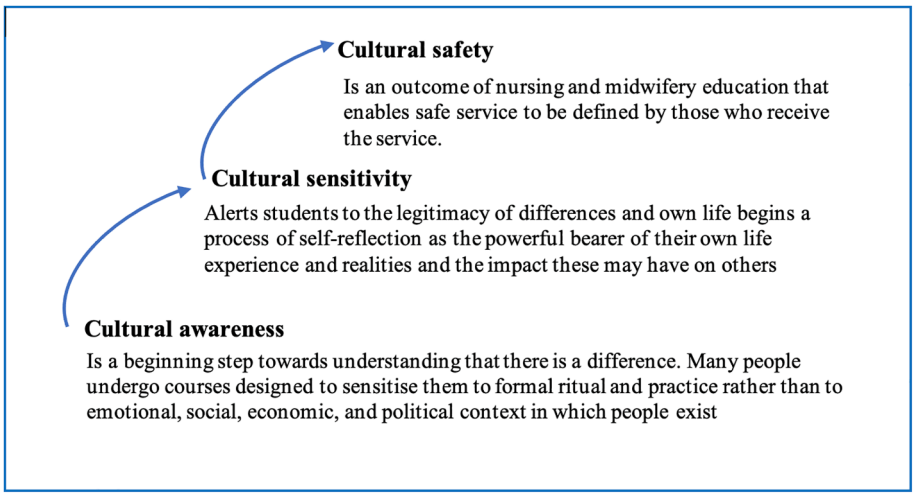

Fig. 1. Cultural safety framework: Adopted from Ramsden (1992).

sensitivity concepts.

2.2. Study design

A qualitative interpretative phenomenology was used. This Heideggerian approach provided the philosophical underpinning that directed data collection, analysis, and interpretation of the findings. Tuffour (2017) recommends this approach as a suitable 'contemporary' methodology due to its 'rich and nuanced insights into the experiences of the participants'. The SBAs insights generated meanings from SBAs lived experiences (Van Manen, 2017) that Heidegger (1962) and Zuckerman (2015) refer to as *Dasein'* being in the world'.

The interpretive Heideggerian approach was suited for exploring awareness of cultural practices by skilled birth attendants during pregnancy and birth, and it 'aligned with researcher's underlying philosophy' (Neubauer, Witkop, & Varpio, 2019), which enabled co-creation of knowledge between the researcher and the participants through an iterative process between the 'part' and 'whole' circle as presented by Heidegger (2010) and described by Neubauer, Witkop, and Varpio, (2019).

2.3. Setting

Explanation of the research setting, participants, and cultural awareness aims to 'open' the study for the reader (de Witt & Ploeg 2006) to relate the study premise with the rationale that influenced the study population's choice to the overall study aim.

Kalenjin is the largest tribe distributed mainly within the Great Rift Valley. Kalenjin is made up of seven subgroups: Kipsigis (1,916,316), Nandi (949,835), Pokot (632,557) Keiyo (313,925), Sabaot (305,000), Marakwet (200,000) and Tugen (109,906). These sub-tribes share common language characteristics, cultural beliefs, and practices, although their geographical locations modify their socio-economic activities (Kenya Information guide, 2018).

The study was undertaken in Keiyo South, a sub-County of Elgeyo Marakwet County, Kenya (see Appendix 1 Fig. 2). Keiyo South people account for 120,750 of the total Keiyo Sub County population of 219,750 (KNBS, 2019). Keiyo South stretches from the Kerio highlands and escarpment (Tenguniin), the hanging valley (Korgeet) and the Kerio valley basin (Soiin) (Safari254, 2020).

It is an area occupied predominantly by the Keiyo people, one of the Kalenjin sub-tribes. It is a rural community partially characterised by hills, valleys, escarpments, and low social-economic resources due to the arid and semi-arid nature of the land. Additionally, along the hanging valley and the valley basin, people still practise their cultural traditions. Therefore, cultural practices are more pronounced, and it is easier to identify them due to less influence by migrants from other cultural backgrounds.

The county government ran the community units through the community committees whereby community health nurse-midwives provided treatment of minor ailments, preventive, and promotive services (Directory, 2018). The dispensaries are managed by the community health nurses-midwives who provide curative, promotive and preventive health services, which includes maternal, neonatal and child immunisations.

The clinical officers, community health nurses or midwives, public health officers, lab technicians and pharmacists run the health centres. Health centre is a referral centre for the community units and dispensaries. The services provided include minor surgical interventions, curative, promotive, preventive and maternity and birthing services. All these health facilities can refer to the sub-county or county referral hospital according to the severity of the cases.

The specific facilities that were purposively selected were the health centres in every constituency. The selection was necessitated by the high number of antenatal, intrapartum, and postpartum client populations due to referrals from the community units and the dispensaries because of the availability of care facilities in the health centres. The community is additionally served by the TBAs, traditional healers, community health workers (CHWs) and community health volunteers (CHVs).

The facilities on the highlands and escarpment are more accessible due to a better road network. However, those along the hanging valley and the basin are more remote, causing access challenges due to distance, valleys and hills, complicating road transport. Motor bicycles 'Boda bodas', bicycles, and motor vehicles facilitate access where the roads are passable, but otherwise, people walked to the facilities when time, weather and health condition allow. Appendix 2 Fig. 3 and 4 show the study site terrain.

2.4. Participant selection and recruitment

The study targeted SBA working in Kerio South facilities that provide maternal and child health services. It was essential to involve the SBAs because of the cultural and geographical characteristics in the Keiyo South. Communities within the Kerio Valley, a part of the Keiyo Sub-County, still believe in their cultural practices. Therefore, the need to understand SBAs awareness of the cultural practices of the local populace.

Purposive sampling of SBAs working in the selected facilities was done. Selection of five facilities recording an average of 20 births and five facilities with an average below 20 births monthly was made. There

were 133 births, 286 antenatal new cases, and 611 revisits on average per month (Elgeyo Marakwet County, 2019); There were 36 public health care facilities in the area, including community health units, dispensaries, and health centres.

Fifteen SBAs from a total of 40 SBAs working in these facilities were selected. Data analysis was done concurrently with the interviews. A total of 15 SBAs were eligible to participate. However, a saturation of themes was achieved after analysing data from the first nine interviews, and the subsequent two interviews did not elicit any new information. Four eligible SBAs were not able to participate due to inevitable reasons.

2.5. Data collection

The first author, an SBA, a Keiyo, conducted the interviews because of personal experience and insight into this community's cultural beliefs and practices. However, the author had never worked as an SBA in this community.

A semi-structured interview guide elicited primary demographic data and the questions that shaped the study themes' formation. The key questions included (i) tell me about yourself: probes (Age, marital status, professional features, tribal affiliation). (ii) let's talk about your understanding of cultural practices: probes (let's talk about cultural practices that you know, tell me about your experiences with cultural practices, tell me what you know about the roles of cultural practices during pregnancy and birth) these questions extracted information that crafted the following themes: (i) SBAs' familiarity with cultural practices, (ii) SBAs' awareness of women's expectations with cultural practices during clinical care and (iii) Challenges to establishing a more collaborative relationship between SBAs, TBAs and childbearing women.

Data collection was undertaken from August to December 2019. The first three interviews were conducted within the first three weeks. Their analysis formed the basis for the initial codes, which guided subsequent interviews conducted weekly with breaks every three weeks to reflect and plan.

All interviews were conducted in the health facility where the participant worked. The rooms provided by the facility management were quiet and away from disturbances. The interview sessions lasted between 45 minutes to 2hours and were audio-recorded. The researcher was fluent in English, Kiswahili, and Keiyo, which allowed the participants to express themselves wholly in whichever language they preferred.

2.6. Analysis

The interview process and data analysis proceeded as overlapping activities in an iterative and reflective course. Progressively, continuous interaction and engagement with the data while incorporating decisions made in every stepwise thematic process cumulatively enriched a balanced integration process (de Witt & Ploeg, 2006) that shaped the emerging themes on cultural awareness. ATLAS. ti Software version 8.4.4 (1135) was used for data analysis. Analysis used van Manen's five thematic analysis steps (Van Manen, 1990) within the hermeneutic cycle (Heidegger, 1962; Neubauer, Witkop, & Varpio, 2019) as described below.

Firstly, the initial three transcripts were checked for accuracy against the audio recordings and field notes. The researcher familiarised herself with the data by reading and re-reading the transcripts to identify possible codes and organise them into categories inductively.

Secondly, transcripts were coded, and initial themes (first-order constructs) were identified. The first, second, and third authors reviewed the analysis's codes, categories, sub themes, and themes. Decisions about important codes were made, and new codes were created through reading and re-reading the transcripts. Codes were either grouped or split based on their relationship with the emerging themes.

Thirdly, steps 1 and 2 were repeated by taking three interviews, then six, then nine and finally, all eleven transcripts were analysed. The analysis of initial transcripts identified issues on cultural awareness that required further exploration in subsequent interviews. This iterative process gradually enabled progressive understanding (Tuffour, 2017) of how SBAs interpreted and attached meanings to their experiences (Van Manen, 2017) with cultural practices that influenced their awareness of cultural practices of the women seeking their services.

Fourthly, second-order constructs from the whole data set were developed. Any connections between different themes were determined and labelled. All three authors examined and refined the themes independently while sharing thoughts until a joint agreement was achieved.

Finally, the mutually agreed themes formed the main findings from the study on SBAs' cultural awareness. The findings present the interpretation of themes, actual quotes from the interviews and interrelationships between themes while also drawing input from the literature (van Manen, 2016) and cultural safety framework (Ramsden, 2002).

3. Rigour

Rigour in interpretive phenomenological studies is guided by the five principles proposed by de Witt & Ploeg (2006); namely, i) balanced integration, ii) openness, iii) concreteness, iv) resonance and v) actualisation. Balance integration and openness were applied to the scope of the study.

As described in the analysis and findings, balanced integration was achieved by articulating interpretivism tenets within the study methods and findings. A comprehensive author's explanation of the SBAs voices' nuances shaped the themes regarding their awareness of cultural practices during pregnancy and birth achieved a balance of these tenets.

As described in the method section and findings, openness was achieved throughout the research process by 'orientating' the phenomenon's characteristics from the topic, the aim, the framework, and the methods. Information relating to the study setting, participants' selection, data collection and analysis process was described clearly to 'open' the study to the reader. Decisions made in the process was accounted for by explaining the rationale for selecting the specific group of participants, the study setting, and the framework. Interpretation of the study findings depicted acknowledging multiple perspectives of the SBAs throughout the experience of exploring their cultural awareness of cultural practices during pregnancy and birth.

Concreteness is an outcome expression demonstrated by the explanation of the implications of the findings for midwifery practice. The study findings described will have a different impact on the reader based on their lived experiences as elicited when immersed, engaging with the study findings on cultural awareness of cultural practices the 'phenomenon'.

Resonance and actualisation are expressions beyond this study's scope because it is judged based on the impact of the findings on the reader.

4. Findings

4.1. Characteristics of participating SBAs

The participants' characteristics enable an 'opening' (de Witt & Ploeg, 2006) through which a better understanding of the SBAs' individualities was achieved in the study. A total of 15 SBAs were eligible to participate. However, four SBAs were not available for the interview due to sickness or travel. Of the eleven SBAs interviewed, five were male, and six were female. The mean age was 36 years and ranged from 23 to 55 years. All participants spoke and understood English and Swahili languages. The SBAs were from the Kalenjin sub-tribes: Keiyo (6), Tugen (3) and Marakwet (2). The SBAs had worked in the MCH departments for a range of 1–30 years, as per Table 1 below.

Table 1
Characteristics of the participating SBAs (N = 11).

Characteristic	Frequency
Age (years)	
20–30	4
31–40	5
41–50	1
51–60	1
Gender	
Male	5
Female	6
Subtribe	
Keiyo	6
Tugen	3
Marakwet	2
Years of employment	
1–10	9
11–20	1
21–30	1
Highest qualifications	
Bachelors	1
Diploma	10

4.2. Key themes

Three main interconnected themes that emerged included (i) SBAs' familiarity with cultural practices, (ii) SBAs' awareness of women's expectations with cultural practices during clinical care and (iii) Challenges to establishing a more collaborative relationship between SBAs, TBAs and childbearing women. Table 2 below presents sub themes which shaped the main themes.

Rigour has been expressed in this section through weaving the quotes expressed by the participants with the cultural safety concepts to interpret meanings that the SBAs described as their multiple realities. Presentation of the study findings followed a process that resulted in the co-creation of knowledge between the author's interpretations of SBAs' understandings and viewpoints from their awareness of cultural practices during pregnancy and birth. Therefore, actual quotes and interpretations of meanings provide a 'balanced integration' of the study concept, thereby 'opening' the study for the readers to understand the conceptualisation of the aspects of this qualitative inquiry.

4.2.1. SBAs' familiarity with cultural practices

This theme emerged from the SBAs having various cultural experiences based on their tribal affiliations, professional experiences, and community influences. The theme had two interrelated subthemes, which included interpersonal relations and cultural positioning.

4.2.1.1. Interpersonal relations. Interpersonal relations that formed SBAs' familiarity with cultural practices involved the TBAs with the women, the women with the SBAs and the SBAs with the women. These relationships created a triangulated relationship that required acknowledging each other's roles during pregnancy and birth. The SBAs acknowledged that the TBAs provided care that women appreciated and saw them as sensitive and caring.

Table 2
Key themes, sub themes.

Themes	Sub themes
4.2.1 SBAs familiarity with cultural practices	4.2.1.1 INTERPERSONAL RELATIONS 4.2.1.2 CULTURAL POSITIONING
4.2.2 SBAs Awareness of women's expectations with cultural practices	4.2.2.1 SBAs PREFERENCES WITH CULTURAL PRACTICES 4.2.2.2 ENCOURAGING UTILISATION OF MODERN HEALTH CARE
4.2.3 Challenges to establishing a more collaborative relationship between SBAs, TBAs and childbearing women.	4.2.3.1 SAFETY DURING CARE 4.2.3.2 FEAR OF DISCLOSURE 4.2.3.3 STRATEGIES FOR ADVANCING CHANGE

The SBAs were cognisant of the relationship between TBAs and the women through stories told by the women. The respect accorded to TBAs in the community highlighted to the SBAs that TBAs were perceived to be more accessible, more aware of women's cultural needs and provided respectful care:

> *"I have not been to them [TBAs] actually, but from what I hear, as hearsay, but not facts, that they give them TLC [tender loving care]. The best care. They give them good care, and they don't harass, they let them deliver at their own pace" (SBA2).*

On the other hand, the SBAs experienced underutilisation of skilled birth services due to women's mistreatment by health care workers. The women experienced the healthcare environment as hostile and would rather stay away:

> *"You see, the way we handle the mothers is not good. They run away. But mostly, it is the attitude of the health workers because if they come and they get harassed, they will never come back [SBAs services]" (SBA2).*

Although the women recognised the importance of skilled birth attendance, they preferred utilising the SBA services for ANC and would utilise the TBAs for birth and postnatal care. SBAs provide technical care, while the TBAs provided more person-centred care. The women and the TBAs assumed that birth would be uneventful if the woman attended ANC without any identified problems. The women then did not attend the third trimester review in the clinic but preferred to go to the TBA until birth:

> *"There are some [practices] which are not encouraged…If the mother comes to the clinic during her first trimester, second and third trimester, then what do they do? She chickens out… So that practice [home birth] should be done away with because we have seen many go to the TBAs and when it backfires, they ran to hospital" (SBA3).*

The SBAs were aware that the TBAs were only able to handle uncomplicated births. Whenever complications arise, there are unnecessary delays in promptly transferring the woman to the health care facility. They may lack essential knowledge and supplies such as the resuscitation equipment and how to manage bleeding or retained placenta. The SBAs compared their readiness to handle complications with what would happen in the health care facility. They indicated the need for SBAs and TBAs to collaborate to provide holistic care to the women and support safe births:

> *"… you work with her (TBA), she sees, and you show her how the baby is received, how the cord is tied and how we (SBAs) measure the cord using the fingers. You tell her that currently, the cord is not tied using a string because of contamination, and she tells you 'That is true'. She feels good, and most of them will tell you 'Aaaii, if this is how things are done, then we leave them for you unless an emergency arises'" (SBA6).*

The SBAs and the TBAs also related directly during care provision in the facility. The experienced TBAs were viewed as a necessary companion for the mother. The women further appreciated it when the TBAs escorted them to the health facility for services from the SBAs. Some SBAs allowed the TBA to provide companionship to the woman during labour. The presence of the TBAs in the health facility was to ensure that women felt comfortable in the new environment:

> *"They don't have a very big role, but the role is supportive and like if the mother brought some clothes, they are the ones to remove the clothes, give them company and to communicate to whoever is at home if there are needs" (SBA 2).*

"Whoever [woman] has not come with the TBA from home are a bit misplaced because there will be no one [TBA] to support her. There will be no one to send if she [woman] forgot baby clothes.…but those who come with the TBA are a bit equipped. They have a string in case she gives birth on the way…porridge…tea and baby clothes so, at least they [TBAs] help" (SBA 9).

Although the SBAs allowed the TBAs to engage with women's care, SBAs were aware that conflict of perceptions existed from the TBAs who felt that the SBAs were young and culturally inexperienced with birthing practices. The TBAs' discomfort with the SBAs' model of care caused friction during birth. The TBAs were further not allowed into the birthing room as they would try and take over the care rather than collaborate:

"They [TBAs] are not allowed to enter birthing [room] because they may end up conducting the birth. They tell you to 'move aside so that I can finish the job '… (wanakuambia songa kando nimalize kazi) …they [TBA] see like you are looking too young, it is like you have not done this job for long [enough experience]" (SBA 10).

On the contrary, the SBAs considered the TBAs as unsafe practitioners who might cause harm to the women, babies, or themselves if they provided pregnancy or birthing services at home. The TBAs allowed women to bear down when, according to the SBAs, the women were not ready. These conflicting practices and assumptions caused friction in the relationships between TBAs and SBAs:

"…I mean, they do the opposite of what you [SBA] are saying…or when you tell them [woman] to wait a bit until there is an urge of pushing, she [TBA] tells her to push. So, you are two contradicting pieces of information. They say, 'we are more experienced', [but] if you tell someone to push at 6 cm, what are you doing? You are causing more harm (SBA7).

4.2.1.2. Cultural positioning. Cultural positioning was portrayed through SBAs' cultural capacity, affiliation, preparedness, and awareness of the community's assorted cultural beliefs and traditions.

How the SBAs approached the depictions of cultural practices was based on their cultural backgrounds, knowledge of different cultural beliefs and practices that influenced their awareness and understandings of the meanings of the practices to the woman and family:

"… she became happy. I allowed that 'shosh' [granny]…I told her spit on her and she spit…to apply oil…because I am also a Kalenjin, so I understand…" (SBA5).

"…that belt for tying the abdomen? (Laughing), yea they say that it helps to return the abdominal muscles. That is what I know about legetiet [traditional belt] according to them" (SBA5).

"It is also believed that after delivery, you are supposed to be away from your matrimonial home for some two months or six weeks…or your husband be away so that you don't be close (Sexually) for that time… for the reproductive system to come back to normal…" (SBA8).

"… you are not supposed to cook for specific age set, the older believed that you are unclean at the time of postpartum…" *(SBA11).*

"If a woman gets breech baby, she is not supposed to step on the grass… some cleansing ceremonies are organised by the TBAs and the 'gogos' [older women] … hoe remedies are there, and they are not bad because what we use here [health facility] are derived from trees…but they should not introduce early…" (SBA4).

"Some foods are restricted, especially eggs and meat. They don't even eat, and they can come with anaemia because they did not get the right diet… they labour for at home… the TBA take long with the mother. At long last, it (delay) compromises the results, and you get a mother coming with maternal distress…because she did not feed well…" (SBA6).

Awareness of cultural information sources in the community highlighted a pivotal knowledge of the community's cultural allegiance. This awareness in turn, highlights the need to modify skilled birthing services to harness and accommodate strengths emanation from this realisation to promote collaborative engagement:

"There are 'kogos' [grandmothers] in the picture…" (SBA7).

"Those traditional healers, elders in the community…those are the ones I can remember…like 'wazee ma mtaa' [village elders] …(SBA4)

"Other sources (of cultural information) are those people who have undergone the practices [abortion]. Like the older ladies who may have done an abortion someday and she gets maybe a friend or a relative underage who gets pregnant, and she knows someone who might. Help… So, it goes back to TBAs. Those are some of the main sources about childbirth" (SBA3).

"Even. The older men. They say, 'an older person has seen more' So there are things that these elders and it is not necessarily a TBA but can influence a certain decision for a pregnant person" (SBA2).

The SBAs' awareness of culture's role to the people and the factors that promoted either survival or 'dying' of practices, knowledge of specific practices with their associated challenges, reflected a critical aspect that influenced SBAs viewpoints during their engagement with the women and the community.

"It is difficult to change culture, there is no way you will change, but the community just need to be informed about the current changes in this century; the culture is there, but some practices need to be reduced or to be avoided, but the culture will still be there" (SBA7)

"Yea, community to diminish it (cultural practices), will be difficult, it will take time. It is not something that will just do it in a day, "…they change slowly but 'sio kuwaacha' (can't abandon) completely just changing and adapting to the new changes but they still observe, 'wasiache' [not to leave] completely. It (cultural practices) is there, yes, but 'sio lazima wafanye yote' [it is not a must that they practice all]' (SBA10).

"The practices which are persisting is that the use of herbal medications for winning. So, I think that one is persisting, because I am seeing that when you tell them to breastfeed exclusively for six months they usually say, "No, 'hata mtoto anatakikana kupewa herbs (even the baby must be given herbs) …. "They say it is water, but you will see that they have boiled something inside…" mostly they say the baby has been born with 'Katet' [needle-pricky pain]… But some are improving. This is the one that has really persisted" (SBA9).

Therefore, the SBAs awareness of familiarity with cultural practices was influenced by the interpersonal relationships created through clinical or community care engagements. The relationship's outcome was crafted within personal cultural affiliations, exposure to cultural expectations and practices of the women, the TBAs, and the community.

4.2.2. SBAs' awareness of women's expectations with cultural practices during clinical care

The two sub themes shaping this theme were SBAs preferences with cultural practices and encouraging utilisation of modern health care.

4.2.2.1. SBAs' preferences with cultural practices. SBAs preferences with cultural practices depicted their general awareness of what they preferred and what the women preferred. The SBAs expressed their opinion on what their preferences were based on their biomedical lens. Their awareness of the community's preferences was considered a community lens of how they view cultural practices and consider modern health care.

The SBAs' formed opinions on practices, women's traditional preferences and evaluated cultural practices through the lens of their clinical practice and what could fit in with the biomedical model. What was not recognisable or aligned with this perspective was rejected. For example, the use of herbs to cleanse a woman of infection during preconception or pregnancy was regarded as chemically "strong" and might interfere with

normal pregnancy:

"I think 'Katet' is like UTI or what? So, they believe that there are herbs that when you drink, they wash that infection before you conceive…in pregnancy, strong herbs are not given." (SBA5).

Some of the unlawful practices in Kenya include the involvement of TBAs in home births, abortions, and female genital mutilation (FGM). Nonetheless, SBAs were aware that the TBAs and older women continued to perform FGM secretly. The community would conspire to keep the "uncircumcised" woman at home. During birth, the circumciser 'Motirioot' performs FGM simultaneously.

The government and health authorities would not be aware of this agreement. In cases that necessitated emergency or hospital care, the TBAs, older women of childbearing women, justified the delay in seeking help due to a precipitate birth on the way to the facility. The TBA would be considered a handy 'good samaritan' on the way to the hospital rather than a perpetrator:

"…I remember 2007 to 2009, there were some issues of secret female FGM, which were done secretly. They (older women and TBAs) did not want to bring primis to the hospital because you find that primis mostly are the female girls who are between 16 and 20 years old, majority of them [women] were not circumcised, so they (TBAs) and elders used to dilly dally (delay) so that the practice is done when the mother delivers, they initiate the girl in the process of giving birth" (SBA6).

The dishonest relationship between the SBAs, TBAs and the women resulted from being culturally compliant. At the same time, the biomedical model did not allow the women or the community to be part of the medical care provided. The community, therefore, found ways around health care practices to be more culturally comfortable.

4.2.2.2. Encouraging utilisation of modern health care. Encouraging the utilisation of modern health care was seen as a practice that was hampered by the community's preference for traditional cultural practices. The SBA's position that the biomedical model was superior to the traditional birth practices emerged as a motivator to encourage the utilisation of SBAs services. The SBAs endeavoured to 'wean' the women away from the traditional cultural practices seen as harmful. The SBAs also endeavoured to integrate some of the harmless traditional practices with the biomedical model to make for synergy:

"When you look into the practice, there are those which can go in line with skilled practices and those ones are encouraged. One is that TBA education given to the community mothers almost goes hand in hand with what we give in the hospital. But there are some which are not encouraged" (SBA 3).

"In the hospital set up, there are those like the celebratory those which are not injurious. If they want to sing, let them sing if they want to dance, let them do so. Those are ok as long as they don't have any harm" (SBA 2).

The SBAs experienced the Keiyo community as patriarchal, where men made decisions about behaviour before and during pregnancy, and the women followed suit when making their choices. However, assisting during the labour and birthing process was seen in the community as a woman's and the TBAs or elders' responsibility. The SBAs saw male partners as potential collaborators who could change their perspectives to uphold safe cultural traditions and embrace SBAs services. Culturally, men did not attend to the birth of the baby in the labour ward; therefore, SBAs considered efforts to encourage their involvement:

"…there were some cultural issues. It was not acceptable for the men to enter the maternity. The community perceived maternity to belong to women alone… due to that, we came up with the notion that if a man comes with the wife or partner, they would be the first to be treated… also, if you see our maternity, we did some structural changes by portioning it and placing curtains so that if the woman comes with her husband, they can pull the curtains to make something like a room then you allow them to stay" (SBA 6).

Further, some men would like to have as many children as possible and take pride in having a big family. The women, therefore, utilised family planning without their partners' consent. During family planning counselling, women could discuss with the SBAs that men leave their partners to get more children with women outside the homestead if the wife fails to conceive:

"…Here, (facility name many women are on modern family planning method (spouse/partner unaware). Some (partners) want to get more babies [but the woman cannot conceive] but cannot tell the woman. You will finally see the man starting to move around (having other partners)" (SBA3).

Women could not disclose the use of family planning methods as the community believed that they caused infertility and the medicines given in the hospitals were the cause of cancer:

"Misconceptions in terms of family planning, they believe that it causes infertility…they also believe that some of the hospital drugs cause cancer" (SBA2).

The need to pursue skilled birth services among the women was affected by the men's and community's beliefs in medical interventions. The SBAs were aware that they would collaborate if the men were encouraged to understand the skilled services better. Ultimately, the women would not feel torn apart between the SBAs services and cultural beliefs.

If the SBAs were aware of these cultural practices, they were more likely to find ways of engaging other role players in women's care during pregnancy and birth and being more collaborative. The desire to promote change enabled the SBAs to find the most effective ways to engage all role players, especially the TBAs. Allowing the TBAs to accompany women during birth was viewed as a strategy for collaborative care by the SBAs if the TBAs did not undermine the SBAs services:

"I just insist on if we can look for ways of how to break that gap between the traditional birth attendants and the health workers. Suppose there is a way that we can set a meeting on how we can support safe deliveries as one thing" (SBA 7).

The SBAs were aware that the TBAs did not feel comfortable identifying themselves in the facility as they were not welcome. For those who decide to accompany the women, most of them posed as relatives. The accompanying relative or TBAs who identified themselves were allowed to provide non-skilled services to the woman. The SBAs took advantage of the TBAs presence as a chance to health educate them. Otherwise, the SBAs utilised the CHWs to link them and the community, TBAs and elders included, because they are part of the community and *would be more respected and have cultural traction.*

"Their role here is to come with the woman…You ask her what she has taught her. You tell them to prepare to receive the baby. You have to tell them so that they feel that they have worked because they are expecting to receive a blanket as a gift for bamwai" (a sponsor in a ceremony) (SBA 7).

"We tell them the signs of danger just little by little, but some of them are not learned yet still they need to know the danger signs… they should be time conscious" (SBA 9)

"Because TBAs cannot come to the facility, we can use these community health workers (CHWs) to reach and educate people in the village to leave some cultures that have no impact and pick positive ones" (SBA4).

Community forums were also utilised for communicating health messages as the women usually attended these forums. The SBAs used these platforms to provide preventive and promotive messages for pregnancy and birth:

"Usually we have barazas [community forums] …women groups, 'Mary go-rounds' [self-help groups] …there are a lot of activities going around. Women have church leagues, and elders teach the young women, a bit of health, STIs (sexually transmitted infections) and that some 'katet' [burning urination] may be due to poor hygiene or witchcraft" (SBA9).

The SBAs were aware that providing services while being conscious of the women's cultural needs and expectations was important. However, previous, and ongoing community, CHWs, and health care workers' health were organised by either the government, non-governmental, or church organisations. Yet, none of these training was culturally specific:

"Culture to come out of Kalenjin (tribal name) is very difficult. For them to tell you that they feel something in their 1% (SBAs refer genitalia-perineum as 1%), For a Kale [short of Kalenjin] issues of 1% you don't talk about them. When one has UTI (urinary tract infection) it is very difficult to tell you that 'I feel something here (genitalia) in their culture that thing is never mentioned… we should understand their culture then handle then according to their accepted ways" (SBA10).

"…understanding is an important thing than acceptance. There are some things you can't change. You handle them the way it is. Like FGM' ish-aafanyika' [it already happened] you cannot tell them 'where were you when they were chopping off your labias?' you will demoralise then, and they will never come to the hospital…You accept the way it is and handle her the way she is in labour or ANC" (SBA2).

The SBAs awareness of women's expectations concerning the cultural practices during clinical care was vital during the engagement with the women, TBAs and the community. It was evident that SBAs were aware that providing services while being conscious of the women's cultural needs and expectations would foster collaborative and synergistic care that would encourage more utilisation of SBAs services and women's satisfaction.

Being aware of the community's preferences highlighted to the SBAs the need to reach the community to provide health education geared to motivating the male partners to be more involved in the women's childbirth journey. The SBAs who were culturally aware of the practices were better positioned to connect more with the women, TBAs and the community during care.

4.2.3. Challenges to establishing a more collaborative relationship between SBAs, TBAs and childbearing women.

This theme emerged through safety concerns that were actual or potential challenges to safe childbearing outcomes viewed from clinical and community perspectives by the SBAs, women, and the community. Coupled with the fear of disclosing pertinent information, harmful practices, and health status concerns by the childbearing stakeholders (women, partners, TBAs, SBAs, community members), barriers to modalities for advancing change towards positive care outcomes for all the potential collaborating partners.

4.2.3.1. Safety during care. Safety concerns by the SBAs emerged as issues with perceived unsafe cultural practices, illegal abortion and other SBAs practising illegally. There were known SBAs who operate illicit clinics in the community and provided abortion services to get more money:

"…Nowadays, abortion still exists. There are a lot of mushrooming clinics… and some of the people are our colleagues" (SBA6).

FGM practices were unsafe practices in the community as the birth canal is restricted, and women may bleed more during birth. The SBAs reported that most of the home births with the TBAs required an episiotomy because of FGM. Women could bleed more because TBAs did not repair the cut with stitches:

"FGM mostly affects childbirth because it causes the birth canal to reduce from outside. It reduces because it has been stitched, so it causes a tear or they, are given some episiotomy causing bleeding to some extent" (SBA7).

Safety concerns also emerged with infection control measures, which were absent during traditional birth attendance. There were concerns that the TBAs had contracted infections such as HIV and were transmitting the same to other women. There was an increase in older women with HIV, most of whom TBAs:

"They (TBAs) should not be referring to their long-time practices…these TBAs…some have contracted a lot of diseases during the childbirth practices because they are not known to use gloves. So, you get a grandmother of age 60 or rather 80 years is HIV positive. Are you getting there?" (SBA6).

The women used traditional healers and TBAs' services as complementary to SBA services. For the women who opted for SBA birthing services, the woman would liaise with the TBAs who would insert herbs into the woman's cervix as an analgesic at term and instructs the woman to go to the health care facility. While performing a routine admission assessment, SBAs would notice herbs in the fully dilated cervix without contractions or any other labour signs due to herbs.

SBAs were also concerned about respiratory suppression in mothers and their newborn babies because of herbs given for analgesia:

"I see many traditions, especially herbs to prevent labour pains do not help because they depress (breathing problems) the baby…at times, the mother can react to these herbs, and you (BA) don't know" (SBA4).

Further safety concerns emerged with an external cephalic version (ECV) practice, which was done secretly by TBAs. The SBAs were aware that ECV may not necessarily have been a cultural practice but adopted by TBAs from observing the SBAs perform ECV. After the ECV, the women might visit SBAs when foetal movements were no longer felt. SBAs attributed foetal deaths to ECV by TBAs:

"They can do an external cephalic version, later, they (women) come and will tell you eeeh…you know… I went to the TBA, who touched me and turned the baby. But after a while, I could not feel the baby playing" (SBA1).

From the perspective of the SBAs, a more collaborative practice with TBAs would need to address their concerns with safety if it was to be successful.

4.2.3.2. Fear of disclosure. The SBAs viewed fear to disclose cultural practices and valuable information for effective maternity care as a deterrent to collaborative care and effective communication. This fear of disclosure was due to stringent government regulations against FGM, home births and abortions.

The TBAs did not disclose their identities for fear of victimisation by SBAs when they brought women to the health care facility. The TBAs identified themselves as good Samaritans who brought the women to the SBA when they were called to help. They did not indicate that they were part of the home birth:

"They (TBAs) are not caught. They don't declare that they are TBAs; they say that while I was passing by, they called me to help, they are traditional birth attendants, so they have not declared that they do [home births]" (SBA7).

Culturally, every family has their TBA and traditional healer. They are consulted as needed and gifted for their services during labour and birth. The SBAs were knowledgeable about some women who preferred to give birth in the facility. In this situation, the woman would allow the TBA to do her part to provide the herbs and escort her. The SBAs encountered this situation because whenever the TBAs escorted the childbearing women at term to the hospital, most women would have

herbs inserted in the cervix, which induced labour and prevented pain.

SBAs reported that the TBAs disguised themselves as relatives to get a chance to attend to the women and prevent them from disclosing who induced their labour. Further, the women protected the TBAs identity because they relied on their services after hospital care:

"…she (woman) came to the hospital, she was in labour because she had induced it. I started to interrogate after seeing some leaves inside there (cervix). Where was that coming from? She reported that a certain woman inserted…I noted that there was a connection (between the onset of labour and insertion of herbs]" (SBA6))

Additionally, SBAs were aware that some women feared attending ANC due to stigma if they tested HIV positive. Fear of being diagnosed and disclosing their HIV status also encouraged women to stay at home rather than visit health facilities. The TBAs were preferred as there was no HIV testing and no fear of stigmatisation:

"…these HIV mothers who have not been tested because they have not gone to the hospital prefer to give birth at home" (SBA5).

Overcoming fears of disclosure about being a TBA and one's HIV status would also be required if a more open and collaborative relationship with SBAs was possible.

4.2.3.3. Strategies for advancing change. Strategies for advancing change were dynamics that the SBAs anticipated would be implemented to effect and modify the prevailing state of cultural behaviours by the women and community, the perspectives of SBAs towards cultural behaviours and the SBAs insistence on utilisation of skilled birth services:

"Male involvement was a bit little. So that was the olden days. But now, we need to encourage them because some decisions (regarding childbearing) depend on them…" (SBA6).
"…involve community decision makers, let them know us, and we know them. 'Inabidi tujipange' [we just need to organise ourselves] …" (SBA5):
"As a facility, we initiated some incentives whereby, when a mother delivers in hospital, she is given some essential items such as basins, sandals, petroleum jelly, pads and that changed the scenario and the issue of women delivering at home" (SBA3).

Collaborative partnership in the childbearing journey demanded conscious efforts from all the partners if anticipated change towards the achievement of favourable clinical and cultural outcomes was to be realised:

"Some of these practices [cultural] come with challenges…especially when they come (women), so we share experiences with fellow workers [SBAs], 'tuna compare' [we compare] notes" (SBA11).

The SBAs suggested that some of the approaches that could be implemented for cultural care capacity building could include incorporating cultural topics in training offered because the training that some of them had attended addressed childbearing information. However, culturally specific topics were not covered:

"We have never conducted any (cultural training). The facility can get elders from around here to come, and we sit together to iron out some challenges…but sometimes we are very busy and getting time to talk just like that is hard (engaging the women, community members) …" (SBA2).
"…the training we went was not specifically on attitude change but was just a whole, it was called..eee..have you heard BEmOC? (basic emergency obstetric care)…so when one goes (training) there is a change of attitude completely, 'yaani' [I mean], you just love delivery…and eee.. there is a lady in our facility who went for respectful maternity care, I did not go for that training, although she never came back to give us feedback, but yea there is a training like that (respectful maternity care)…the lady who went is called (name mentioned)" (SBA1).

Identification of agents for advancing change was advocated based on existing mechanisms and experiences that promote transformational changes:

"The in-charge (facility manager) can talk to world vision guys (non-governmental organisation doing nutrition projects in the community) to come and train us here (facility). At least, they have gone around these villages, and they know their cultures better…they can link us through .. ee… you know we have the CHVs…" (SBA8).
"Because during the sessions (outreach), we used to attend the church meetings; there are these seminars found in a majority of the churches, so we used to send our team to go and sensitise women about the services in the facility, so it was a way of marketing ourselves" (SBA9).
"So, 'Kitambo' [a while ago], I was here in 2007, so if I relate 2007 and 2018, people are now more informed… I see these ICT (information and communications technology) has played a role; radio, TV, schools have done a lot of sensitisation. Also, the church, back in the community, the moment those people [community members] go to 'Baraza' [community forum], they share a lot. When they share a lot, one weighs own scenario and that of the neighbour (adjacent person). So, the community inspire themselves, then the leaders and administration inspire them. Then they embrace change…" (SBA6).

The SBAs awareness of the challenges related to safety and disclosure status affecting establishing a more collaborative relationship between SBAs, TBAs, childbearing women and the community highlighted some gaps that motivated the SBAs to consider ways to address them. Additionally, the relationships' strengths further inspire the SBAs to be more sensitive to the relational attributes to be harnessed positive maternity experiences for the providers and the users.

5. Discussion

Cultural awareness among SBAs enabled receptiveness to women's cultural needs and expectations during care. Exploring SBAs' awareness highlighted their familiarity with cultural practices, facilitating more knowledge to appreciate women's expectations with clinical care. These challenges created an opportunity for change to achieve a more collaborative relationship among the stakeholders, as shown in Fig. 2.

5.1. Familiarity with cultural practices

The sub themes interpersonal relations and cultural positioning interpret the data on familiarity with cultural practices. Many of these cultural experiences were as a result of birth attendants engagements with childbearingwomen. The nature of the engagement either evokes positive or negative experiences among the stakeholders. The SBAs cultural characteristics play a role in influencing how they appreciate the women exhibition of cultural behaviours.

Sociocultural, poor attitude, unethical behaviours (Chang et al., 2018), 'discriminatory view of indigenous' communities and lack of culturally appropriate policies (Wahlström, Björklund, & Munck, 2019) affect perceptions and engagement between the health providers and the community. Ethical and care modalities dilemmas may influence the SBAs' experiences and perspectives due to a lack of cultural sensitivity, socio-cultural differences with their clients, a focus on institutional and professional rather than community tenets, more mechanistic biomedical care, and organisational policies (Guerra-Reyes, 2016).

This study addresses familiarity gaps among engaging stakeholders through culturally based professional development to improve culture care. Community approaches to promote 'mutual respect' and collaboration can enhance cultural safety, positive birthing experiences and outcomes (Corcoran, Catling, & Homer, 2017; Tesfaye et al., 2017).

5.1.1. Interpersonal relations

New interpersonal relationships emerge during care engagements. These relationships were between childbearing stakeholders (the SBAs,

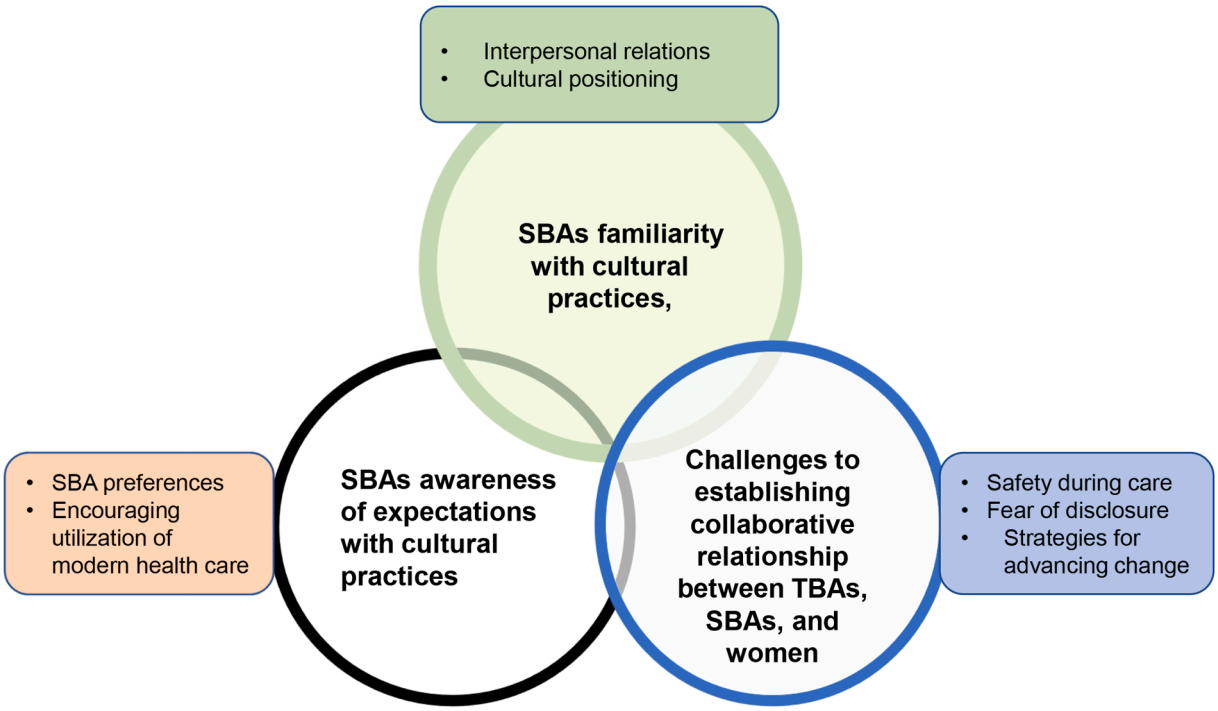

Fig. 2. Thematic representation.

TBAs, community link persons and the community members). The nature of relationships is created to influence the outcome of care provided or received. Ultimately, the relationship's outcome depends on the nature of power-sharing among these partners that influence their connections. As seen in this study, relationships suffered dynamics that affected adequate care provision and collaboration. Therefore, power structures in care relationships need a new focus to transform the status quo in maternity care (Curtis et al., 2019).

A systematic review by Downe et al. (2019) showed that 'relationship-based care, with 'culturally appropriate links', will improve the community's utilisation of skilled birth care. This study painted a picture of relationships characterised by secrecy, distrust, dishonesty, criticism, and fear. These relationships are away from the goal of mutual respect and collaboration' (King et al., 2015) and culturally safe midwifery care described in the literature (Curtis et al., 2019; King et al., 2015).

5.1.2. *Cultural positioning*

In this study, cultural positioning emphasised how culture is an inextricable aspect of the childbearing journey. Most SBAs are aware of the common cultural practices and behaviours within the immediate community. Practically, SBAs are expected to provide holistic care that incorporates woman's cultural needs and expectations. Still, they are 'bound' by regulations advocating for skilled birth services through the modern care medical model mandate. Regulations restrict them from exploring the complementary benefits to skilled care to promote safe and satisfactory childbearing experiences for the women and the care providers.

Most cultural beliefs and practices are not harmful and could have 'physiological benefits' and continue to define women's care decisions (Raman et al., 2016; Withers et al., 2018). Health care providers and policymakers who acknowledge and appreciate cultural influences on childbearing improve care quality and reduce maternal mortality. Therefore, "it is important for providers to be aware of the most common practices within their contexts" (Withers et al., 2018) to move towards culturally safe care.

This study identified that cultural practices were a significant and often hidden influence on SBAs and childbearing women's relationships. The factors shaping these relationships are consistent with the existing evidence indicating that cultural practices are diverse, but their cultural constructions are specific to the women's context. Therefore, SBAs need to consider their care approaches to meet women's preferences by activating their cultural awareness (Lang et al., 2020; Withers et al., 2018).

The study findings on SBAs familiarity with cultural practices has illuminated gaps and strengths in culture caregiving. Attention is needed to modify midwifery education, health sector practice policies, and community empowerment (Luisi and Hämel, 2021). Also, through building trust, enhancing power-sharing, collaborative engagements (Hulsbergen and van der Kwaak, 2020), adopting flexible protective approaches to cultural practices to achieve woman-centred care for positive childbearing outcomes and experiences (Petit-Steeghs et al. 2019).

5.2. *Awareness of expectations with cultural practices*

The SBAs' awareness of women's expectations regarding cultural practices was influenced by their cultural positioning based on personal cultural affiliation, openness to cultural exploration, their professional identity, and the amount of work experience in the community.

The SBAs' awareness of 'what women want' during care, while they continue to promote modern care as the 'truth', highlights the need to integrate provider's and user's preferences. The goal is to achieve a balance that is culturally appropriate for the women and professionally and ethically acceptable for the SBAs. This would require a more collaborative approach to care that allows negotiation and partnership in the care process (Berndt and Bell, 2021; Townes et al., 2020).

5.2.1. *The SBAs preferences with cultural practices*

Their preferences and encouragement of utilising modern care services influence SBAs awareness of expectations with cultural practices because stakeholders in the woman's journey through pregnancy harbours expectations and justifications towards their own and other's practices using a contextualised lens. While the SBAs saw modern care as

the 'truth', the women's and the community's experiences with the 'truth' may differ.

The SBAs preferences highlighted their awareness of the community's decision-making systems, which are expected to enlighten them on those specific systems. There is a need to heighten the SBAs' awareness of these processes to enable the women's needs to be met without imposing unnecessary tension during care engagements. Facilitating mutual understanding through SBAs' self-reflection and modification of their interventions is vital (Yanagisawa, Ayako, Igarashi, Ura, & Nakamura, 2015).

The SBAs preference for SBA services because they considered the 'truth', 'right' may create barriers to wholistic health care provision opportunities. This apparent appreciation of the benefits of skilled service utilisation, culturally diverse and complex backgrounds of the woman and the SBAs should motivate the SBAs to address these challenges. However, Brown et al. (2016) indicate that despite the midwives being aware of the cultural barriers, they may not be able to 'analyse' to label them as 'potential threats to culture safety'.

The SBAs were aware that women attended ANC clinics but preferred to give birth with the TBA at home. This knowledge should engage the SBA to realise that SBAs and SBA services such as 'poor antenatal care' may be barriers to utilising the services (Mehretie Adinew et al., 2018).

5.2.2. *Encouraging utilisation of modern health care*

While encouraging the utilisation of modern health care, SBAs know that the care environment should be culturally safe when women travel to the facility. Women expect care that meets their cultural needs and expectations. This is an ideal expectation. This study revealed that SBAs had diverse preferences, experiences, and expectations regarding cultural practices affected by their backgrounds, cultural encounters in their practice, and personal effort to accommodate various cultural practices.

Khatri et al. (2017) identified 'contextual barriers' that are important for improving SBA service utilisation. They include 'difficult geography, poor birth preparedness practices, harmful cultural practices and traditions and low level of trust'.

Other potential ways of improving SBA utilisation can be achieved by involving CHWs and (CHVs) as 'conduits of change' (Mitchell et al., 2016; Sialubanje et al., 2015). There is also a need to encourage women to be more autonomous in making appropriate SBAs care decisions while SBAs are aware of the impact of social status, cultural considerations, and communication challenges that could hinder possible change (Sialubanje et al., 2015; Bohren et al., 2019). Additionally, improvement of service provision, health system management, improved quality of services, cultural training for the provider and sensitisation of the recipient on SBA services would enable uptake of skilled services (Khatri et al., 2017).

Critical areas of attention are to dismantle the biomedical model monopoly by the community members and traditional model by the community members and embrace a complementary approach to caregiving. Both entities can create a mutual agreement grounded on awareness of strengths and weaknesses through a cultural assessment of what women want (Kerrigan et al. 2020; Ndaba, Taylor, & Mabaso, 2020; Pham, Koirala, & Kohrt, 2021).

5.3. *Challenges to establishing a more collaborative relationship between SBAs, TBAs and childbearing women*

Safety concerns, fear of disclosure, and strategies for advancing change in this study illuminated the SBAs', TBAs', and the women's challenges. These challenges impede collaborative relationships that are essential for more culturally sensitive care (Munabi-Babigumira et al., 2017). Therefore, there is a need for sensitisation of the care providers on the cultural needs and expectations of the childbearing women and the community. Strategies to advocate for shared decision-making and collaborative partnership in care provision should be implemented nationally and institutionally (Downe et al., 2019; Fowler et al., 2018; Nasir et al., 2020).

5.3.1. *Fear of disclosure*

Fear of disclosing cultural practices reduces modern healthcare access, resulting in poor maternal and neonatal outcomes (Khatri et al., 2017; Sumankuuro et al., 2019).

While the woman's HIV positive status was not a cultural practice, it fueled her family's fear and the community's impact due to the stigma's influence (Kinuthia et al., 2018). Therefore, HIV status becomes a barrier to the woman from achieving optimal skilled birth services, preventing HIV vertical transmission, and maintaining general health status (Markos Kachero, & Arba Kinfe, 2021).

5.3.2. *Safety concerns*

During care this emanated from cultural practices and inclusion or exclusion of pertinent cultural or clinical care aspects by the TBAs, SBAs, women, SBAs, women, and communities. The community accords more importance to the traditional care model, yet risks are associated with the practices (Raman et al., 2016; Withers et al., 2018). For instance, FGM 'promotes' a girl to become a respectable woman. This value is the reason that motivated the elders and some TBAs to continue performing FGM secretly while the woman was giving birth at home. Unfortunately, its adverse effects during childbirth are notable (Fox and Johnson-Agbakwu, 2020).

The value supersedes the fear of strict legal measures in place against FGM. The communities' unrelenting effort to achieve cultural rite highlights a possible motivational tension between accepting government caveats and gaining cultural identity (Lang et al., 2020). Health institutions need to spearhead the generation of the alternative passage of rites in collaboration with community leaders and health improvement teams to safeguard women's respect while maintaining maternal safety (Muhula et al., 2021).

The SBAs' preparedness through training, experience, and attitude modification influence women's choice of provider. Acknowledging the importance of cultural awareness by SBAs increases cultural sensitivity, therefore ensuring women are more comfortable with the care. Women appreciate the care that preserves their cultural identity while being clinically safe (Downe et al., 2019; Mitchell et al., 2016).

Herbal remedies are practices that have continued to gain momentum and are universally used and valued in the community. The users justifiably protected their use. Home births with TBAs have continued to be popular. They are affiliated with several other cultural practices such as herbs, seclusion, and dietary modifications, which may complicate the childbearing process (Wilunda et al., 2017).

Fear of disclosing information on issues considered 'secret' was related to cultural practices and modern care interventions, such as modern contraceptive use and fear of victimisation by the community elders. Women do not readily surrender cultural information to the SBAs due to fear of victimisation or stigma (Fox and Johnson-Agbakwu, 2020; Wilunda et al., 2017). Some TBAs' practices are outlawed despite some benefits contributed by this group.

Women embraced modern family planning services, yet they hid this information from their spouses because they saw this as beneficial yet unacceptable to the community. The SBAs reports on women's struggles with balancing cultural with modern care interventional dilemmas highlight possible motivational tension. This tension can be a possible chance for the SBAs to explore and exploit for further understanding of what women go through to achieve their needs and expectations (Lang et al., 2020).

During the SBAs engagement with the women, the SBAs can use the chance to enlighten the women to explore the benefit-harm ratio in looking for solutions for resolving decisional conflicts. The women will consider the influence of some valued external goals by weighing the decision balance when making childbearing decisions (Mash, Mash, & De Villiers, 2010).

Resolution of decisional conflicts may be different within other cultural contexts globally, but other practices influence disclosure status. For instance, women's fear of disclosing the use of herbs (Peprah et al., 2019), FGM practices (Fox & Johnson-Agbakwu, 2020), abuse (Spangaro et al., 2016), HIV status (Kinuthia et al., 2018) and pregnancy disclosure (Sumankuuro et al., 2019). These findings are similar to this study that underscored how the disclosure status influenced adequate SBA care provision and women's care satisfaction.

Community and modern care barriers contribute to the fear of disclosing pertinent information that influences care. However, there are ways of mitigating the impact related to disclosure status. Notably, Curtis et al. (2019) and Sumankuuro et al. (2019) advocate for improved community health education, culture training for the providers, and implementation of elements of culture safety'.

5.3.3. Strategies for advancing change

SBAs were aware of strategies that could create both clinical and cultural safety. For instance, SBAs were cognisant that women value a partnership throughout their childbearing journey, particularly while giving birth. Facility operational modalities created barriers to the woman's and the family's expectations of 'being together'. The SBAs advocated for exploring channels of change that will promote care satisfaction and positive childbearing outcomes through mutual understanding among the stakeholders.

Mehretie Adinew et al. (2018) and Mitchell et al. (2016) highlight challenges against effective care to include adequate ANC, provider's efforts, and utilisation of CHVs and proper management of change process without compromising people's values to their practices. Modern care is a foreign environment for the community. Therefore, Ganle et al. (2019) suggest that women have labour support to promote positive birth outcome and experiences.

The SBAs professional care competencies also influence the experience of care provided and received. Therefore, building professional and cultural capacity among the care providers supports a positive care environment that allows the women to receive quality clinical care and feel culturally safe (Downe et al., 2019). Therefore, targeted culturally specific professional development implementations can address the challenges (Sumankuuro et al., 2019).

Healthcare providers should be educated on counselling skills to enable a woman-centred safe space for them to comfortably voice harmful practices and pertinent information that could otherwise be concealed due to caregiver's repulsive responsiveness or the community stigmatisation that fuel effects of unmet needs (Bernardes et al., 2020; Hardin et al. 2021).

Additionally, timely advice on the impact of dietary modification, especially the restriction of proteinous foods, will prevent nutritionally based complications. Complimentary or alternative nutritionally equivalent choices can be planned collaboratively with the woman and significant other people and follow up nutritional assessment and management should be instituted (Riang'a et al., 2017).

6. Strengths and limitations

This study included SBAs who engage with childbearing women, TBAs and the Keiyo community, allowing for an in-depth understanding of their experiences with cultural practices. The qualitative findings were thought to be based on a sufficient sample and engagement to enable an in-depth understanding. In this article, the findings were through the eyes of the SBAs and the findings may be different if viewed from other healthcare professionals, women, or TBAs' perspectives. Purposive sampling method was employed on the participants who were thought to be 'information rich'. The researcher may be biased in the sampling process. Additionally, analysing the vast narratives into interpretive themes was time consuming and meaning of the respondents' experiences may be lost in the interpretation. However, review of the research and consensus process by the all the researchers helped in mitigation bias and misinterpretation of meanings. The findings may be transferrable based on similar characteristics of the setting, the participants, and methodological approaches.

7. Conclusion and recommendations

Research findings illuminated SBAs' awareness of cultural practices. Personal cultural positioning, professional experiences, and the immediate community influenced this awareness. SBAs experienced a tension between their awareness of cultural expectations amongst the women and their need to encourage utilisation of modern care services. Cultural barriers to a more collaborative care relationship between SBAs, TBAs and women resulted from women's and caregivers' fear of disclosing important information that would promote cultural safety. This study may be replicated elsewhere by adapting the methodological, and theoretical approaches.

The SBAs' awareness of these challenges and ways of building on their existing relationships could allow the SBAs to engage with strategies to promote change. Further studies could focus on promoting cultural sensitisation of the health care providers and community outreach services to understand better the cultural behaviours of the communities they serve. Sensitisation will reduce the gap between the medical and the traditional care models.

8. Author contributions statement

TKN Envisioned and executed the research processes: data collection, analysis, and interpretation of the findings. The entire process was under the supervision of D.KM. K, and BM. TKN Developed, organised, and revised the manuscript, critically appraised, and approved by D.KM. K. and BM.

Ethical statement

The research involved human participants. Ethical approvals were granted by Stellenbosch University Health Research Ethics Committee (HREC REF: S18/10/255) on 26/04/2019 and Africa Medical and Research Foundation (AMREF) Ethics and Scientific Review Committee (ESRC REF: P642/2019) on 27/06/2019.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ijans.2022.100394.

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