



## Learning lessons from a traditional midwifery workforce in Western Kenya

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### ABSTRACT

**Objective:** to learn lessons from a traditional midwifery workforce in Western Kenya.

**Design:** with the assistance of an interpreter, qualitative data was collected during in-depth individual and group interviews with traditional midwives. English components of the interviews were transcribed verbatim and the data thematically analysed.

**Setting:** a rural, economically disadvantaged area of Western Kenya.

**Participants:** 84 participants who practise as traditional midwives.

**Findings:** it was common for these traditional midwives to believe they had received a spiritual gift which enabled them to learn the skills required from another midwife, often but not always their mother. The participants commenced their midwifery practice by learning through an apprenticeship or mentoring model but they anticipated their learning to be lifelong. Lifelong learning occurred through experiential reflection and reciprocal learning from each other. Learning in colleges, hospitals and through seminars facilitated by non-government organisations was also desired and esteemed by the participants but considered a secondary, though more authoritative source of learning.

**Key conclusions:** the primary learning strategies used by the participants enabled them to have confidence in physiological birth; birthing women; and their own skills as traditional midwives.

**Implications for practice:** learning from women and continued professional reflection are ways of learning for midwives that may increase their confidence in women, birthing and their midwifery skills. These attributes are essential for midwives, regardless of their workforce context.

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### Background and introduction

The purpose of this study is to explore the experience of being a traditional midwife and to learn lessons both about and from the traditional midwifery workforce. Globally, it is estimated that one-third of birthing women will be supported by a traditional midwife (often referred to as a traditional birth attendant but not a skilled birth attendant) and in sub-Saharan Africa it has been estimated that two-thirds of women access traditional midwifery care during labour (Krueger, 2009). Most women in rural Western Kenya, the setting for this research study, will access a traditional midwife during labour; the minority will birth in an institution; a few will be supported by family members; and some will birth alone (Population Council et al., 2004; Dietsch, 2010; Ouma et al., 2010).

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A midwife is a person who has successfully completed a midwifery educational programme, duly recognised in the country in which it is located. They have acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery (International Confederation of Midwives, 2005). In contrast, a traditional birth attendant (TBA) has not satisfactorily completed a prescribed course of studies to enable them to be legally licensed/registered in their own country. However, this paper will refer to the traditional midwife, rather than the traditional birth attendant in deference to their observed midwifery skills and experience, which have been observed by both authors over a six-year period prior to the commencement of the study and as a mark of cultural respect. Women in the area refer to the 'mkunga' (Kiswahili word for midwife) who serves them in their villages; the traditional midwives call themselves 'mkunga' and the health professionals in the institutions refer to themselves as 'daktari' (doctor) or 'mwuguzi' (nurse), but not midwife ('mkunga'). The popular use and title midwife, in this area of Kenya, refers only to the traditional midwife or TBA.

Access to health professional care (skilled birth attendance) has been nominated as the key indicator for the 5th Millennium

goal of reducing maternal mortality by 75% between 1990 and 2015 (United Nations, 2007). However, maternal mortality rates, conservatively estimated at 526 (405–683) per 100,000 live births in sub-Saharan Africa and 238 (172–328) per 100,000 live births in South/South East Asia (Hogan et al., 2010), are not due to the status of the care provider alone (Scott and Ronsmans, 2009; Sorensen et al., 2010). Women are dying as a tragic consequence of poverty, gender inequity, violence against women, malnutrition, inadequate family planning, poor transport and communication infrastructure and contaminated water supplies as well as from inequitable distribution of health care (Chalo et al., 2005; Tuguminize, 2005; Chandy et al., 2007; Arps, 2009; Cox, 2009).

In an attempt to address the unacceptably high maternal and newborn mortality rates in resource-poor nations, a shift in global policy direction occurred in the late 1990s to focus on increasing women's access to skilled birth attendant (health professional) care during childbirth (Kruske and Barclay, 2004). However, efforts and intent to ensure 90% of women have access to a skilled birth attendant have failed and are highly unlikely to be met (UNICEF, 2008; Krueger, 2009). Even if it were possible to ensure skilled health professional care in a medical institution for all birthing women, evidence to suggest that this strategy would significantly impact the maternal and newborn mortality rate has been questioned (Bang et al., 1999; Costello et al., 2004; Bowser and Hill, 2010; Nair et al., 2010). Bang et al. (1999), Costello et al. (2004) and Nair et al. (2010) argue that community based neonatal care with traditional birth attendants has some benefits over institutional care, including the capacity for these community based interventions to reduce both maternal and newborn mortality. Furthermore, Bowser and Hill (2010) report widespread disrespect and abuse of women within institutions which limit their potential to provide acceptable care when required. It is unlikely that institutional birth with a skilled birth attendant would be acceptable to most birthing women (Bullough et al., 2005; Costello et al., 2006; Harvey et al., 2007; Marton, 2009). In recent years, the status of the traditional midwife has been eroded because, no matter how experienced or competent, by definition a traditional midwife is not considered a skilled birth attendant. The traditional midwifery workforce has become invisible as they are no longer considered to have a place in international global health policy (Kruske and Barclay, 2004; Saravanan, 2008; Krueger, 2009).

An extensive and integrative review of the literature demonstrated that the published research has focused on an assumption that maternal and newborn mortality rates would automatically be reduced when women in economically disadvantaged nations had access to the same models of intrapartum care dominant in resource-rich nations (Dietsch and Mulimbalimba 2010). Little attention has been paid to social factors impacting on child-bearing women's morbidity and mortality (Costello et al., 2004, 2006). A small number of studies has engaged women, community members and traditional midwives themselves as informants and these provide invaluable insights about the human impact of maternal mortality/morbidity and the role and practice of the traditional midwifery workforce (Anderson et al., 2004; Adams et al., 2005; Chalo et al., 2005; Dietsch, 2005; Tuguminize, 2005; Waiswa et al., 2008; Arps, 2009; Bazant et al., 2009; Jeffery and Jeffery, in press). This paper will explore the experience of being a traditional midwife and report on lessons all midwives can learn from the traditional midwifery workforce.

## Methods

Every step of the qualitative research process was directed by service-based principles and methodology (Dietsch, 2006). Being

service-based in design, the project focused on ethically sound, culturally safe research methods. Culturally safe research methods are those where researchers are aware of cultural differences, acknowledge the legitimacy of cultural difference and reflect on their own cultural identity to ensure they are not being detrimental to any other person from a culture other than their own (Phiri et al., 2010). The service-based research process placed an emphasis on identifying and reducing power differentials between researchers, interpreters and participants. Issues that were important to the participants and likely to bring about positive and more equitable outcomes for them were explored from the perspective of being a traditional midwife in the western area of Kenya. The rationale for selecting this particular research setting is congruent with service-based research principles where trust and mutual respect between researchers and participants have had time to build and there is reciprocity as ideas, experiences and knowledge are shared (Dietsch, 2006). Both authors have spent time in this region and have worked closely with traditional midwives, including some of the participants. The region identified as being one of the most socio-economically, disadvantaged areas on Kenya (Population Council et al., 2004; Ouma et al., 2010) suffered further from the violence, rape and murder that emanated in late 2007/early 2008 following the national election and then the drought which destroyed the subsistence crops that so many in the region depended on (Kenya Red, 2009).

Eighty-four participants, identifying as 'mkunga' participated in the study in late 2009. The second author identified 24 traditional midwives as potential participants and all consented to be interviewed. The remaining participants were recruited through a snowballing effect. The exact age of almost all participants was unknown to them, but estimated to be 18–80 years, with most around 40 years of age. Of the participants, 83 were female and one was male. Participant literacy and numeracy skills were, for the most part, very limited. For this reason, numerical data must be considered estimate only. Participant experience as a traditional midwife ranged from a few months to over 60 years. There were wide variations in the number of women supported by traditional midwives to birth each year. Some participants reported working in group practice with each group having three traditional midwives and a trainee who was learning from them. Group practices reported supporting 250–500 women during labour and birth per annum, almost all of whom had also received at least one antenatal visit. Traditional midwives working individually reported supporting between 5 and 74 birthing women per annum with most caring for approximately 20–30 birthing women per year. All participants had provided intrapartum midwifery care for at least one woman in the three months (wet season) prior to interview.

Although both authors have worked with some of the participants over a number of years and had observed their traditional midwifery practice, for ethical reasons only data collected from participants during interviews was analysed and reported on. Individual interviews took place with 18 participants and the remaining 66 participants were interviewed during group interviews. Individual interviews were the preferred data collection strategy but group interviews proved to be a pragmatic necessity as the number of traditional midwives seeking to participate was more than three times the number anticipated. Many traditional midwives, having heard about the study from other participants walked together for many hours in the hope that they would be interviewed. The traditional midwives had an overwhelming desire to tell their stories and to have their stories heard. It would have been disrespectful and culturally insensitive to have turned the potential participants away but because of the dangers of walking into the evening on their return home, ten interviews

needed to be conducted with a number of participants present. Group interviews ranged in size from three to ten participants but were not considered focus groups as the intent was not to study ways that the group collectively made sense of their experience nor was it to construct group meanings about being a traditional midwife. Whether individual or group, all interviews were in-depth and contributed to thematic analysis.

Only one researcher (first author) was involved in interviewing and they were assisted by one of two Bukusu/Kiswahili/English speaking interpreters. Interview settings included participants' homes, clinics, churches, fields and community halls. All interviews were audiotaped and the English component/translation transcribed verbatim. To enhance rigour, transcribed interviews were thematically analysed by the two researchers and three themes identified and agreed on by both researchers were reported on.

Each interview opened with the request 'please tell me as much as you can about what it is like for you to be a traditional midwife'. The remainder of the interview then followed the participant's lead with conversational prompts and questions used when clarification was required. If the topic of resources did not arise during the interview, questions about the use and effectiveness of simple birth kits (a small bag containing a plastic sheet, soap, gloves, cord clamp, sterile scalpel and gauze squares) were asked.

Being a transcultural study, ethical considerations included ensuring cultural safety for all participants and utilisation of an interpreter in a way that did not exacerbate power differentials between participants and the research team. Special consideration was given to strategies to ensure participants provided their informed consent. All information sheets and informed consent forms were translated into Kiswahili but given the limited literacy skills of many of the participants, the informed consent process was explained to potential participants by the second author in the weeks prior to the project commencing. Potential participants were advised that there would be no financial or other remuneration should they choose to participate but they would receive light refreshments and have their bus fare remunerated. Whether or not they chose to participate or withdraw from the study at any time, they would not be disadvantaged in any way and their access to resources such as birth kits would remain unchanged. When potential participants arrived unexpectedly to be interviewed, the same process was followed by the interpreter who explained the informed consent forms in Bukusu/Kiswahili before participants were interviewed. Consent forms were either signed or marked with an 'x'.

Working with a translator requires careful consideration including ensuring accuracy, minimising bias and reducing power differences as the translator inevitably interprets and assigns meaning to words in both languages (Pitchforth and van Teijlingen, 2005; Wong and Poon, 2010). There are no known professional translators in this area of Kenya and so the second author, who is fluent in Bukusu/Kiswahili and English advertised the positions, interviewed five applicants and appointed two translators. Selection criteria included that the applicant be neither a traditional midwife or a skilled birth attendant, have very good English and Bukusu/Kiswahili language skills and were able to articulate the importance of following ethical principles, for example maintaining confidentiality, providing unbiased interpretations, treating all participants with respect and valuing whatever the participants said. Random selections of each taped interview were played to the second author following the interviews and the accuracy of translations were verified or rarely, some additional clarification was provided. The study received approval from the Charles Sturt University Institutional Ethics Committee (2009/45).

## Findings

Thematic analysis revealed three major themes, all of which include lessons that can be learned about and from traditional midwives. First, that for these participants, being a traditional midwife means being in relationship with women and skilled birth attendants. Second, that being a traditional midwife means having access to valuable resources. However, it is the third theme that is the focus of this paper; that being a traditional midwife involves lifelong learning. The theme of lifelong learning has three subthemes which include: being a traditional midwife means to receive a gift; being a traditional midwife means valuing knowledge that is imparted in many different ways and finally that lifelong learning leads to having confidence in labouring women, the birth process and their own traditional midwifery skills.

### *Being a traditional midwife is a gift*

As the quotes from the participants indicate, any woman who had ever birthed was referred to as 'mum' or the more respectful, 'mamma'. The participants also referred to each other and the interviewer as 'mamma'. Many participants spoke of learning to be a midwife from their mother, grandmother, mother-in-law and the women they served. Their learning was commonly integrated with a belief that their midwifery knowledge was a spiritual gift:

[I have] not learned anywhere but here. This is a gift of God ... [my] mother, a midwife ... I used to watch my mother (Participant, individual interview 14).

It's an inheritance, [we] seeing our mums. Our grand-mums (Participant, group interview 9).

Four participants described learning some of their midwifery skills through the gift of dreams:

I learnt to be a midwife in that dream. After one year I had another dream about a mamma whose baby was breech and I learnt what to do to help a mamma. The next day when she came to see me and her baby was born by his bottom [that was] in 2004 (Participant, group interview 4).

I dreamt that there's a traditional medicine they use to stop the bleeding ... [I] came across the young woman who was just bleeding ... and I gives that [traditional medicine] to girl and she stopped bleeding ... this medicine can still slow down the bleeding, as experience then [I] find it was true (Participant, individual interview 16).

### *Being a traditional midwife means valuing knowledge that is imparted in different ways*

Some participants had been given an opportunity to learn midwifery skills through short courses provided by colleges and hospital staff. Most participants had attended seminars facilitated by staff at the Non-Government Organisation (NGO) that was responsible for the distribution of birth kits. This more formal learning opportunity was an experience they valued:

These mamas learn from the training college ... they have got a certificate ... they were learning just a week. One week at the college (Participant, group interview 19).

Trained at [government] hospital ... [for] 3 weeks (Participant, group interview 1).

We try to go to different seminars with different doctors. Then we learn in different way because you can go to a seminar and

they show you how you can treat and do [midwifery] (Participant, individual interview 11).

The one male participant discussed how he originally learnt from supporting his wife during childbirth. His experiential learning led to him becoming an accepted traditional midwife for other women in the village:

[I] chose to become a midwife. It's because I help my own wife to give birth to ten children, whereby they didn't have a problem and because [of] that ... in my life ... [I] help other people (Participant, group interview 1).

However, the most common learning model was mentorship or an apprenticeship with another traditional midwife. The length of time spent in apprenticeship varied from three months to three years. Some traditional trainee midwives lived with their mentor during their training; others would be called whenever a woman was labouring:

[I] stayed for three months at [traditional midwife's] place (Participant, group interview 1).

[I was] three years learning with [traditional midwife] (Participant, individual interview 25).

There is an expectation for lifelong learning. The participants learn from their own experience and this was exemplified by the participant who demonstrated through miming, a classic somersault manoeuvre for dealing with a nuchal cord:

Babies who had their cords ... around their neck ... [I] have experience of that ... so I just take my finger and I touches ... the action. [I] gradually lifted up and over the baby's head (Participant, group interview 18).

The participants learn from each other when they meet every few months to collect their supply of birth kits:

We just change ideas lots of the time, some will tell us her problem. For example, sometimes when her mother delivers, it's difficult for the placenta ... so when we meet we change ideas, how the placenta ... sometimes you get a mother, she's bleeding, so when we just meet, we change ideas (Participant, group interview 4).

Although the participants esteemed the skilled birth attendants who worked in the hospital because they had uniforms and a certificate, the care women received in the hospital was often critiqued:

Lying on the back ... Sometimes the baby's in good condition and if you lie down like that ~ the baby comes in bad condition ... And then they take her and do an operation (Participant, group interview 20).

*Being a traditional midwife means having confidence in labouring women, the birth process and our own skills*

The participants had confidence that women would birth and birth well. They spoke of following the woman's lead in labour and in giving the woman the time needed to birth well:

[I] cannot force the mother to give birth ... dancing ... walk around when they are in labour (Participant, group interview 2).

The first thing ... they enter ... we talk to them softly, we entertain them ... when the mother is ready ... she can tell you anything she wants, she is ready to, she's open with you and then you start examining her, checking her (Participant, group interview 4).

Not only are the women seen to be capable but the birth process itself is something in which the participants have confidence. Birthing was not feared but trusted and celebrated. The participants sharing the two vignettes to follow mimed their practice during second and third stage respectively, as they described their role:

On the floor and so the mamma ... encourage the mamma ... the baby's coming and the baby's beautiful ... Mother's ready, is pushing the baby and the baby's coming. Then the mother bring the baby, slowly by slowly. When the head is out ... the mother deserve to have a rest ... because the pressure is surround, the baby is now out ... when the baby's out, take the baby, put breastfeed ... cut the cord, yep, after clamping it ... cover the baby, keep the baby warm (Participant, group interview 20).

Then the mother and her baby are together, [I] not force the placenta. [I] will wait and ... then I will see the signs ... the cord is [lengthening] ... and slight blood ... then the placenta slides out (Participant, group interview 20).

The participants in this study often spoke of their confidence in being a traditional midwife for their community:

[We] are saying that [in hospital] they use technology to do that job, but they need to go to college. But [we] have experience (Participant, group interview 10).

Also, being a midwife is to save the woman's life ... otherwise the mother would be dead sometimes (Participant, group interview 20).

Their reputation in the community as proficient and caring midwives was essential if they were to continue practising:

[I am] proud because [I'm] popular in [my] village. Everybody knows [me] because [I'm] a midwife (Participant, individual interview 24).

For me, what I enjoy, to be a midwife, I assist the mothers to give birth well, and babies grow well, they go to school, they learn well, and sometimes when I do that, some people in the area, they come to me, because I help mamma giving birth well. They don't go to hospital for operation ... [I] just get a good name when I deliver well, because then that mother ... tells others how good they got from me (Participant, group interview 4).

A good reputation meant that women would seek out the services of the traditional midwife and they would receive payment, either in cash (the equivalent of A\$2–\$10 for all antenatal and intrapartum care) or in kind:

Happy when the babies are alive and I am just paid ... in cash (Participant, group interview 2).

When [I do] delivery well, [I'm] proud because [I'm] going to eat my meat (Participant, group interview 4).

Their confidence in being able to provide women with the midwifery support required to birth well emanated from the participants' trust in the ways they learnt and continue to learn as midwives.

## Discussion

The participating traditional midwives have confidence in the physiology of childbirth, the ability of women to birth well and their skills to provide woman-centred midwifery support. Their

confidence mirrors the concept of 'self-knowledge' described by Hunter (2008). That is, the participating traditional midwives believe what they know, know what they believe and act on those beliefs. The participants' confidence was not founded on knowledge from a medicalised/authoritative source but was rather, an embodied knowledge in that it was a knowledge emerging from practice and/or experience (Jordan, 1978).

In contrast, legally licensed/registered midwives acquire at least their base knowledge through formal midwifery programs in what Habermas (1972, 1974) described as empirical/analytic (technical) means. The expert imparts knowledge to the learner in an asymmetrical relationship where the educator acts as an epistemological gatekeeper as to what will be taught, how and when. In contrast, most participating traditional midwives described learning in partnership with a mentor and each other, in a style described by Habermas as historical/hermeneutic (communicative). Although both knowledge acquisition styles have their place, it has been argued that the most comprehensive knowledge acquisition comes from critical (self-reflective) learning (Habermas, 1972, 1974) or 'self-knowledge' (Hunter, 2008). Furthermore, reflective learning is enhanced when power differentials in the learning/teaching environment are minimised or even reversed to allow learning to be equitable, fluid, comprehensive and deep (Van Manen, 1977; Lovat et al., 2004).

However, effective reflective learning is as a way of knowing midwifery, it is not esteemed to the same extent as formalised, institutionalised knowledge acquisition. Ways of acquiring knowledge are reciprocally linked to types of power. Authoritative knowledge is vested in those with authoritative power and authoritative power is vested in those with authoritative knowledge; this is maintained by those in authority and those who believe they are dependent on those with the power. In the context of this study, it is NGO health professionals who facilitate seminars and distribute the highly valued birth kits. It is the hospital doctors and nurses who have the power and the authoritative ways of knowing and it is the traditional midwives and women who are dependent on hospital health professionals for assistance in an emergency. The health professionals' position and power are easily maintained through their elite higher education and certification, symbolic uniforms and their use of technology (Walton, 2009).

The participants in this study perceived their reflective and reciprocal learning as valuable but nevertheless, deemed training and education received in colleges, hospitals and seminars facilitated by health professionals as the more powerful and prestigious. The knowledge they gained in these institutional settings may or may not have been evidence-based, but for the participants, the knowledge was powerful solely because of its source and potential for certification. Sources which are deemed to have authoritative knowledge were therefore considered of greater value than their own experiential learning.

In both Western and Kenyan settings, a woman's own subjective knowledge and a midwife's knowledge of physiological birth gained through experience are considered of less value in an all-consuming birth culture that considers medical knowledge as authoritative and technology of value (Gould, 2000; Jordan and Aikins Murphy, 2009). The traditional midwives in this study valued their knowledge and experience and the woman's own subjective knowledge but believed both were devalued by a technocratic hospital system. The dominant ethos, power and prestige afforded by technology, legitimised authoritative knowledge, certification and uniforms are able to remain unchallenged. The fact that participating traditional midwives maintained their confidence in women, birth and themselves reflects their resilience as a midwifery workforce.

Power is the dominion of those who have the capacity to provide or withhold resources from another, thereby maintaining the power status quo (Dacher et al., 2003). As previously stated, it is the NGO with the best of intentions that provides or withholds the birth kit resources. In the context of global midwifery, the title midwife is a highly valued resource but it is formally withheld from anyone who has not satisfactorily completed a midwifery educational programme (empirical/analytic (technical) skills acquisition) to provide them with the qualifications enabling registration/legal licensure in their country of practice (International Confederation of Midwives, 2005). Although the legally licensed midwife is synonymous with the title skilled birth attendant, the traditional midwife's skills are not assessed and because they are unknown by those who hold the power, traditional midwives are assumed to be unskilled (Chandy et al., 2007). It has been argued that because traditional midwives support the majority of labouring and birthing women in the resource-poor nations of sub-Saharan Africa, significant improvements in the maternal and newborn mortality rates will only become evident when traditional midwives are perceived as colleagues and potential lifesavers rather than dangerous and unskilled under-performers (Costello et al., 2006; Chandy et al., 2007).

### Limitations

The study design, purpose and intent were not to measure confidence in ability and no comparisons to actual knowledge of physiology of childbirth can be made. As a cross-cultural project attended with the aid of a translator, strategies to ensure trustworthiness of the data were employed. Nevertheless, utilisation of a translator is an identified limitation. The participating traditional midwives anecdotally confirmed the previously heard argument that traditional midwives in this area of Kenya have maternal and newborn health outcomes more favourable than the local government and private hospitals (Sophie Kibuywa, Policy Analyst, personal communication, 13 January 2005). The possibility that women perceived as high risk or experiencing complications are more likely to birth in an institution and skew outcomes cannot be ignored. However, the qualitative nature of this study and the paucity of conclusive evidence make it impossible to verify that women and their newborns accessing traditional midwifery services in this area have more or less favourable outcomes compared with those accessing skilled birth attendance in a hospital. Outcome evaluation would need to be determined through future mixed methods research. Given the low literacy level of most participants, information pertaining to numbers, for example, the reported number of birthing women supported per annum, must be interpreted with caution.

### Implications for practice

It is common and not poor practice for health professionals, including midwives linked to the NGO that distributes birth kits, to facilitate seminars for traditional midwives in this area. These seminars often focus on risk assessment, prevention and management of obstetric emergencies as well as effective use of the birth kits. The seminars are valued by the participants and should continue. However, the participating traditional midwives also have much to teach professional midwives about the physiology of childbirth and the ability of women to birth well. It is recommended that opportunities be provided for reversing the usual learner/teacher roles where the expertise is believed to be with the professional midwife alone. Both traditional and professional midwives can learn reflectively from themselves and each

other. Reflective learning and knowing flourishes in an environment where there is acknowledged equality and symmetry between participants in the learning/teaching context (Van Manen, 1977; Lovat et al., 2004).

Midwifery in western nations has a fear-based perception of birth (Cragin and Powell Kennedy, 2006) which is thought to be responsible for much of the unnecessary interventions embedded in midwifery care (Hood et al., 2010). In contrast, the participants in this study had a respect for and confidence in birth. Their ways of learning and knowing can provide lessons for midwifery practice and education globally. Midwifery models that value the childbearing woman, not as an object to be used in learning but rather as a participant in and author of midwifery education have the potential to reduce some of the fear of childbirth currently embedded in midwifery practice. Midwifery curricula and lifelong learning strategies that enable midwife–woman relationships to develop, are enquiry based, focus on reflective learning and are woman-led are required.

## Conclusion

Lessons learned from a traditional midwifery workforce in Western Kenya have been outlined in this paper. Their ways of learning and knowing as traditional midwives were primarily experiential and reflective and although more formalised education imparted by professional birth attendants was valued and considered prestigious, it was not their principal source of knowledge. The lack of formal education and their illiteracy does not negate the knowledge base of the traditional midwifery workforce participating in this study. The majority had never had any formal midwifery education, had never read a midwifery or obstetric textbook but they had certainly studied women, birthing and the practice of other traditional midwives supporting childbearing women. Experiential and ongoing learning has taught these traditional midwives to have confidence in birthing women, the physiology of labour and birth and their own midwifery skills. These are lessons that all midwives, regardless of their workforce context would do well to learn.

## Ethics statement

Charles Sturt University (CSU) Institutional Ethics Committee approved the project (2009/45).

## Conflict of interest statement

Dr. Luc Mulimbalimba-Masururu is the Medical Director of the Mission in Health Care and Development (MHCD) and Dr. Elaine Dietsch, an Australian Midwifery Academic attends faculty practice with traditional midwives associated with MHCD on a voluntary basis each year. MHCD is an African, not for profit, non-government organisation (NGO). It identifies the role traditional midwives play in serving the needs of women in the Democratic Republic of Congo (DRC) and Kenya who otherwise would birth alone or with relatives to support them. MHCD provides support in terms of partnering traditional midwives and acknowledging their skills and experience, providing ongoing professional education, facilitation of peer support and learning and the dispensing of birth kits. However, neither author has any financial or other conflict of interest from the writing of this paper.

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