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Busia County's Transformation of Maternal Health through Zero Home Deliveries

County:	**Busia**		
Sector/s:	**Health**	**Sub-sector/Theme:**	**Maternal and Child Health**
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Target Audience:	**Counties**		
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Introduction:

Busia County, a vibrant borderland region serving as Kenya's gateway to the East African Community, has demonstrated remarkable resilience in transforming its healthcare system. However, healthcare in border Counties like Busia faces numerous challenges. Poor road networks, difficult terrain, and lack of identification documentation create significant physical barriers. Financial hurdles, such as the high cost of cross-border healthcare, the need for foreign currency, and the non-transferability of health insurance policies, further complicate access. The County has also borne the brunt of epidemics, including mpox, red eye disease, Ebola scares, and COVID-19, due to international travel, further straining the health system. These issues are compounded by shortages of quality healthcare infrastructure and skilled personnel, as well as language barriers that hinder patient-provider communication. Underlying these challenges are disparities in national legal and institutional frameworks, which dictate healthcare entitlements and create inconsistencies in service delivery protocols across borders.

Despite these obstacles, Busia County has made significant strides in improving maternal health outcomes. One of its most notable achievements is the elimination of unskilled home deliveries in Kamuriai Location, Malaba North Ward, a community previously overwhelmed by high rates of childbirth conducted by untrained Traditional Birth Attendants (TBAs).

Kamuriai Location, comprising Korisai and Osasame sub-locations, had long struggled with unsafe home deliveries. Poverty, lack of awareness, cultural preferences, and logistical barriers, such as long distances to health facilities and fears of mistreatment by medical staff drove mothers to seek delivery services from TBAs. These practices posed severe risks, including postpartum hemorrhage,

retained placenta, and neonatal complications. Additionally, cross-border dynamics, such as intermarriages and lack of identification documents, further complicated access to formal healthcare services.

Implementation of the practice (*Solution Path*):

Figure 1: Inception sensitization and training sessions between the chiefs, Nyumba kumi members, village elders, Community Health Promoters (CHPs), and Traditional Birth Attendants (TBAs)

Recognizing the maternal health challenges faced by women in the community, the County initiated a partnership with local actors including chiefs, Nyumba Kumi members, village elders, Community Health Promoters (CHPs), and Traditional Birth Attendants (TBAs). This partnership began with sensitization and training sessions aimed at equipping stakeholders with the knowledge and skills to address unsafe delivery practices.

TBAs, who were key actors in home deliveries, often provided their services for a small fee, as low as KES 20, or in exchange for foodstuffs when clients could not afford to pay. Most TBAs had inherited their skills from grandparents or acquired them informally while working in hospitals as subordinate staff. Besides conducting deliveries, many offered traditional massage services, which some mothers continue to request to date.

Acknowledging that their livelihood was at stake, TBAs were trained separately on the dangers of home deliveries, the importance of skilled attendance during childbirth, and safe maternal care practices. Some TBAs gave heartfelt testimonials about traumatic experiences during deliveries that resulted in maternal deaths due to their lack of medical training. These stories reinforced the urgency for change.

Figure 2: CHPs engaging the community members on the dangers of unsafe delivery practices

To ease the transition, TBAs were offered an alternative role as birth companions. In this role, they accompany expectant mothers to health facilities for antenatal care and delivery. This strategy was effective because many women felt safer with TBAs, whom they trusted more than nurses due to prior experiences of mistreatment.

The sensitization campaign extended to the community level, beginning with village-by-village visits led by chiefs and CHPs. These efforts included dialogue days, community barazas, and forums designed to openly discuss the risks of unskilled deliveries and promote facility-based births. Chiefs played a central role by initiating health talks and involving CHPs in engaging men and husbands, helping them understand their role in supporting their spouses throughout pregnancy and ensuring clinic attendance.

To enhance impact, community stakeholder meetings were organized involving the National Government Administrative Officers (NGAO), CHPs, Community Health Committees (CHCs), TBAs, religious leaders, and Community-Owned Resource Persons (CORPs). These sessions aimed to sensitize key opinion leaders and collectively condemn unskilled deliveries. The resulting framework, developed with guidance from the Sub-County Community Health Strategy Focal Person (SCCHSFP), fostered strong multi-sectoral collaboration and promoted social accountability.

The County Government supported this initiative by funding community outreach programs, providing incentives for health workers, and covering transportation and referral logistics. Training was also extended to CHPs and community members to strengthen the health system at all levels.
As a result, CHPs now conduct early mapping of pregnant women within their communities, ensuring timely follow-up and linkage to health services. The engagement of community leaders, especially chiefs, has played a crucial role in sustaining awareness and reinforcing behavior change.

Results of the practice (*outputs and outcomes*)-

- The shift from home to skilled deliveries was achieved by retaining TBAs as birth companions. They now build trust, escort mothers to health facilities, monitor hesitant cases, and facilitate referrals, strengthening community confidence in healthcare.
- Local chiefs and religious leaders drove change through regular meetings, barazas (public forums), and awareness campaigns.
- The initiative was supported by a well-structured resource mobilization strategy. Funding from DANIDA enabled the development of educational materials, provision of transport for emergency referrals, and financial incentives for health workers to enhance motivation and

retention. Partnerships with local stakeholders further reinforced the initiative, ensuring sustained momentum and preventing a return to unskilled deliveries.

Lessons learnt:

- Strong leadership from chiefs and local health officials proved critical for driving behavior change, as they provided consistent guidance and mobilized community participation.
- Engaging TBAs rather than sidelining them successfully built trust within the community while bridging cultural practices with modern medicine, making the transition to facility-based deliveries more acceptable.
- Community-driven solutions demonstrated greater effectiveness and sustainability compared to top-down approaches, as they incorporated local perspectives and fostered ownership of health initiatives.
- Involving men and entire family units in maternal health decisions led to better outcomes by addressing household-level barriers and creating a support system for expectant mothers.
- Consistent training and open dialogue maintained accountability among stakeholders while keeping community members invested in sustaining positive health practices.
- The availability of skilled healthcare workers and adequate facilities was necessary to handle increased referrals and maintain the zero home delivery record over time.
- Collaboration among diverse stakeholders, including health workers, local leaders, and community groups, strengthened both implementation and long-term sustainability of interventions.

Recommendations:

- Continued integration of TBAs as maternal health champions through ongoing training and small incentives to maintain their vital role in promoting facility deliveries.
- The model should be expanded to other regions and Counties facing similar challenges, ensuring that adaptation aligns with local contexts while preserving core principles.
- Establishing partnerships to provide transport vouchers or delivery care packs, further incentivizing hospital births and reducing financial barriers.
- Maintain regular community dialogues to ensure continuous improvement, address emerging challenges, and preserve the community's sense of ownership over maternal health outcomes.

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Photo Gallery – Community barazas and forums to discuss the risks of unskilled deliveries and promote facility-based births