BMJ Open

Unlocking the potential of traditional birth attendants in Somaliland: a qualitative study on healthcare system integration

Jama Ali Egal ,[1,2] Amina Esse,[3] Fatumo Osman ,[4] Kerstin Erlandsson,[5] Marie Klingberg-Allvin[6]

To cite: Egal JA, Esse A, Osman F, *et al*. Unlocking the potential of traditional birth attendants in Somaliland: a qualitative study on healthcare system integration. *BMJ Open* 2025;**15**:e097956. doi:10.1136/bmjopen-2024-097956

► Prepublication history for this paper is available online. To view these files, please visit the journal online (https://doi.org/10.1136/bmjopen-2024-097956).

Received 13 December 2024
Accepted 05 December 2025

[1]Health and Welfare, Birmingham City University - Edgbaston Campus, Birmingham, UK
[2]Faculty of Nursing and Midwifery, University of Hargeisa College of Medicine and Health Sciences, Hargeisa, Please select, Somaliland
[3]Faculty of Nursing and Midwifery, University of Hargeisa College of Medicine and Health Sciences, Hargeisa, Woqooyi Galbeed Region, Somaliland
[4]Dalarna University, Falun, Sweden
[5]Dalarna University, Falun, Dalarna, Sweden
[6]Karolinska Institutet, Stockholm, Stockholm, Sweden

Correspondence to
Dr Jama Ali Egal; jaa@du.se

ABSTRACT

Objectives The roles and functions of traditional birth attendants in the community and in relation to the formal healthcare system have to the best of our knowledge, not previously been explored in Somaliland. This study aimed to explore the past and current roles and practices of traditional birth attendants from the traditional birth attendants' perspective.

Design An exploratory study was conducted using purposive sampling technique first followed by snowballing technique from January to December 2023.

Setting Somaliland rural communities in the six regions of the country.

Participants Traditional birth attendants from all six regions of Somaliland were interviewed. Thematic analysis inspired by Braun and Clarke was used to analyse the data.

Results Traditional birth attendants were historically involved in pregnancy care, childbirth and the practice of female genital mutilation/cutting. Their role has undergone a significant shift in recent years. Traditional birth attendants are increasingly acting as vital links between the community and the formal healthcare system. They report that they have maintained strong trust within their communities, which positions them as effective mediators in promoting access to professional maternal and reproductive health services.

Conclusion Traditional birth attendants are becoming trusted intermediaries between the community and the formal healthcare system. In the pursuit of universal health coverage and the goal of delivering high-quality, equitable care for all, leveraging traditional birth attendants as part of a broader midwifery-led care model offers a cost-effective strategy in the Somaliland context.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ Native-language, open-ended interviews by native researchers enhanced data reliability and captured rich personal and contextual insights.
⇒ Purposeful regional sampling ensured diverse experiences; thematic saturation was reached with recurring key themes.
⇒ Lack of data triangulation (eg, midwives, health officials, service users) reduced trustworthiness and limited the holistic understanding of traditional birth attendant (TBA) roles.
⇒ No focus group discussions limited multiple data sources, exploration of group dynamics and may have constrained the depth and robustness of findings.

INTRODUCTION

Between the 1970s and 1990s, to reduce maternal deaths, the WHO invested in training traditional birth attendants (TBAs) which was successful in reducing stillbirths and perinatal and neonatal deaths, but unsuccessful in reducing maternal deaths.[1 2] The operational definition of a TBA in this study is in accordance with the joint WHO/UNFPA/UNICEF statement from 1992.[3] TBAs are persons who acquire their skills in assisting childbirth by apprenticeship to other TBAs and, in turn, assisting mothers during childbirth. In contrast, Skilled Health Personnel (SHP),[4] particularly midwives and obstetricians, have professional proficiency in the skills needed to manage both normal and complicated pregnancies, births and follow-ups through the identification, management and timely referral of women and new-borns for specialist treatment. Therefore, the global strategy changed the aim to focus on scaling up access to SHP, in particular midwives, to reduce maternal mortality in developing countries. However, when there is a severe shortage of SHP, TBA continue to conduct home deliveries.[5] Most deliveries in low-resource settings are predominantly assisted by TBAs.[6] While it is evident that earlier large-scale efforts to train TBAs did not significantly reduce maternal mortality,[7] our study does not advocate for TBAs to replace SHP. Instead, we refocus on TBAs to explore their evolving complementary role in bridging the gap between communities and formal health

systems in settings where access to Skilled Birth Attendnats (SBAs) remains limited, rather than reverting to previous models where they were trained to deliver births independently. This approach aligns with recent WHO and International Confederation of Midwives (ICM) guidance calling for context-specific roles for all health actors in transitioning to midwifery models of care.[7 8] Midwives trained and regulated according to ICM global standards can provide 87% of the total sexual reproductive health needs of the population and are associated with improved health outcomes.[9–11]

Somaliland's self-declared independence from the Republic of Somalia after a civil war in 1991 remains unrecognised by the international community. According to the most recent health demographic report (2020), maternal mortality is high, at 396 deaths per 100 000 live births. Somaliland deals with an extreme shortage of midwives who can provide complete health coverage for maternity care. As a result, 67% of women have a home birth supported by a TBA.[12–17] TBAs have been involved in practices targeting women and young girls in villages, ranging from performing Female Genital Mutilation/Cutting (FGM/C), fertility treatment, pregnancy basic support and home deliveries.[18] In Somaliland today, midwives provide most of the care for women in pregnancy, labour and postnatally, both in community and health facilities.[12] However, the actual number of midwives regulated is low, and the scarce resources to educate adequate numbers are challenging for the country. Midwifery education institutions in Somaliland follow ICM standards for midwifery education to improve the quality of maternity care.[19 20]

A recent qualitative study with women in Somaliland showed that a lack of reproductive agency in facility-based births makes women choose home births with TBAs, regardless of the risks or the women's medical needs. Considering that TBAs are currently conducting most of the deliveries in Somaliland,[12–14] there is no scientific evidence focusing on TBAs' roles in the community or in relation to the formal healthcare system in Somaliland. Hence, the aim of the current study is to explore the past and current roles and practices of TBAs from TBAs' perspectives, which is vital for successful resource planning and improvement of the quality of maternity care in Somaliland.

METHODS

Study design

This study used an exploratory study design, in which individual open-ended interviews were conducted with TBAs from all six regions in Somaliland (See table 1.)

Setting

Somaliland is located in the Horn of Africa, bordering Djibouti, Ethiopia and Somalia, with a coastline along the Gulf of Aden. It has an estimated population of around 5.7 million people, living across six regions: Awal, Sahil, Maroodi-Jeeh, Togdheer, Sanaag and Sool. The country's health system is challenged by limited resources and infrastructure, with approximately 316 public health facilities including hospitals, health centres and maternal and child health (MCH) centres distributed unevenly across urban and rural areas. Much of the population lives in remote or pastoralist communities, making access to healthcare, particularly maternal and newborn services, a significant concern.[21] All health services are managed by the Somaliland Ministry of Health Development (MoHD), where midwives are the main providers of maternity care in hospitals and the MCH. This study was conducted from January to December 2023.

Table 1 Semi-structured interview guide

Introductory questions	Can you tell me about yourself and how long you have worked as a TBA? How did you become a TBA, and what motivated you to do this work?
Questions on the past and current roles and practices of TBA	What were your responsibilities in caring for women during pregnancy and childbirth in the past? Can you describe your involvement, if any, in traditional practices such as FGM? What kind of support did women expect from you when giving birth at home? How do you see your role now compared with when you started? In your view, how has your work contributed to the development of midwifery in your community? What do you think about the increase in trained midwives in your area? Can you describe any traditional remedies or treatments you still use? How do you help women in need? What are your responsibilities in the community today? How do you educate or advise women and families on health issues? Can you describe any community activities you are involved in? How would you describe your relationship with midwives or health workers at these centres? What happens when you meet a woman who needs urgent medical care during pregnancy or birth? What are your hopes for the future role of TBA in your community?
Closing questions	Is there anything else you would like to share about your role as a TBA? What message would you like to send to policymakers or the health ministry regarding TBA?

FGM, female gender mutilation; TBM, traditional birth attendant.

Participants and data collection

The source population for this study was TBA working in rural communities in the six regions of Somaliland. The

inclusion criteria for this study were TBAs who were actively involved in maternal health services within the selected communities, had experience with both traditional practices and linking the formal healthcare system and were willing to participate and provide informed consent. TBAs who had not been involved in maternal health activities in recent years or were unable or unwilling to participate in interviews were excluded from the study. Participants were identified with the help of local health offices. A purposive sampling technique was used, followed by a snowballing technique based on their experience and relevance to the research aim, and to ensure the inclusion of TBAs from all the different socio-geographical backgrounds.[22] The local health offices have facilitated a meeting with their community midwives, urging them to support connecting the research team with TBAs in rural communities in that region.

The semi-structured interview guide was constructed and piloted by the first author to ensure clarity and cultural relevance of the questions. The semi-structured format provided a balance between structure and openness, helping to generate rich, comparable and contextually grounded data.[22] (Please see table 1 semi-structured interview guide.) These pilot interviews were transcribed and checked for completeness and depth of data relating to the aim. Invitation letters were handed out to the participating TBA by the first author (JAE), and the content and aim were orally described. Those who agreed to participate were given an introduction to what to expect during the interviews. An appointment for an interview was agreed on, and they were informed that they were free to withdraw from participation at any time without any consequences. The interviews were conducted in the respondent's home. None of the TBAs who had given their oral and written consent dropped out of the study. The TBAs were asked about their experiences during home births, transition to the MCHs and their relationships with SHP. Interviews were conducted in Somali, lasted between 55 and 65 min and were tape recorded. Data were collected until no new information was available to collect.

Analysis

The interviews were transcribed verbatim and translated from Somali to English according to WHO guidelines.[23] A qualitative thematic analysis inspired by Braun and Clarke was conducted manually.[24] This approach was chosen to allow the researchers to remain closely engaged with the data, enabling a deeper and more reflexive understanding of the participants' experiences. The first step of the analysis was familiarisation. The transcripts were read several times to make sense of the content and to become immersed in the data. Second, all transcripts referring to the aim were extracted and condensed. In step three, the condensed texts were given individual headings (codes). In step four, similar codes were grouped into subthemes. The subthemes were further divided based on their different contents. Subthemes with similar content were grouped together to formulate a main theme. (See table 2. Themes and subthemes of the analysis process.) For inter-coder reliability check, KE, FO and JAE read through the original transcripts to ensure credibility. The themes and subthemes were discussed between the authors without disagreement and consensus was met. The authors engaged critically in all steps of the data analysis and used reflexivity throughout the process to ensure that our analysis was grounded in the data at a manifest level. This approach allowed us to identify meaningful findings that provided new and insightful understanding of the evolving roles and practices of TBA in Somaliland.

Patient and public involvement

Patients and/or the public were not involved in the planning, conduct, design, reporting or dissemination of this research.

RESULTS

The research team connected with four TBAs per region, resulting in conducting 24 interviews. See table 3, Demographic characteristics of the participants. Themes and subthemes are presented below and in table 2. The variety of quotations are stated by the TBA number.

Being a bridge between the community and the healthcare system

The overarching theme of this study shows that TBAs have the capacity and status to bridge between the community and healthcare system in hard-to-reach areas, especially in rural settings, for timely referral of women to health facilities. Three main themes emerged from the data of this study.

TBA being the backbone that paved the way for midwives

TBAs' role in pregnancy, delivery and FGM

The TBA explained how they started their work in their communities during the 1980s. They never planned to become TBA. Instead, it was a response to the urgent need to attend to and support women in their community. A TBA reported that after the civil war in Somaliland, everyone had to flee the cities and ended up in settlements over the Ethiopian border, mostly in the mountainous areas. Women arrived at these settlements with some already pregnant and experienced adverse delivery outcomes and newborn mortalities due to the extreme stress they experienced from leaving their homes and excessive walking to find safety:

One TBA said, *"I started in 1988 when we were fleeing, I delivered the first woman. I don't know how I supported her, it was for the sake of Allah, I said my God please support me and he did! I had never delivered a baby before, it caught me off guard, there was no one with us, we were on the run trying to escape being killed and I still remember, she cried don't leave me alone please."* (TBA 8)

The TBA explained how they were presented with the difficult situation of assisting births when there was no

Table 2 Themes and subthemes of the analysis process

	Themes	Sub-themes
Being the bridge between community and healthcare system	TBA role in pregnancy, delivery and FGM	TBA being the backbone that paved the way for midwives. ► TBAs' views about how they started and their role in midwifery services today ► TBAs were women's only hope since the war and deserve respect as they make way for qualified midwives ► TBAs are decreasing in the western parts of the country due to increased midwifery education
		TBA conducting FGM and assisting home-based births. ► TBAs and being with women and how they support them ► Women want to be respected Expectant management because it is the only thing that they can do ► TBAs' roles in FGM ► TBAs report that they feel a lack of skills and competence in signs of emergency early pregnancy complications ► TBAs collect food, clothing and money from the community for women in need ► The use of herbal remedies at home
	TBAs' transition to community mobilisers	TBAss functions and roles in the community ► TBAs are very respected by the community ► TBAs receive regular training and updates from non-governmental organisations ► Training for young parents on parenting ► Educating women/families in the community about healthy eating TBAs are a critical part of the community health mobilisers used by the MOHD and NGOs ► Talking to mothers about child spacing ► Anti-FGM training from NGOs ► TBAs perform outreach activities with fathers and religious leaders ► TBAs advise families on aspects based on their training by midwives
	TBA in transitioning to become the link between the community and the healthcare system	TBAs' transition from homes to mother and child health centres ► TBAs working closely with midwives in the MCH ► TBAs' relationships with qualified midwives ► TBAs transfer women for ANC and delivery ► Many TBAs have continued into midwifery training ► TBAs refer women to MCH during pregnancy and birth ► Many TBAs currently work in MCHs ► Some TBAs benefit skills and medications from MCHs
		TBAs' wishes for the future ► More training to build their capacity ► More support and payments for TBAs still working in the eastern parts of the country, who are still filling a gap in maternity services ► Somaliland should never forget the difficult times TBAs have provided lifesaving services for women and their babies

FGM, female gender mutilation; MCH, maternal and child health; MOHD, Ministry of Health Development; NGOs, non-governmental organisations; TBA, traditional birth attendants.

one else around. They expressed the stress they felt and the sense of courage and duty to support women with whatever they could remember from their birth situation or any close woman they witnessed during labour.

One TBA said, *"During the civil war, I fled to Ethiopia, so I resided in the refugee camp and one day, the women who lived in the shelter next to me laboured and other neighbours said please come and support her, I never perform delivery before but I kept in mind how I was supported during my birth, so it was less difficult."* (TBA 16)

The TBA explained that they were trying to save women's lives and that they did not understand at all how they managed to do that. The TBAs viewed trained midwives as their daughters and sisters and have never felt that there was competition, but it was important to them that people do not forget all the work TBAs have done for women and their communities over the years and during the conflict. They explained the importance of being respected for the difficult times they bravely worked for saving women's and children's lives in Somaliland.

One TBA said: *"I never thought I had enough knowledge; we had the trainings but because we lack many other things, we will never feel we can compete with trained midwives, yet we have saved women's lives and never complained so now we deserve to be respected."* (TBA 2)

TBA conducting FGM and assisting with home-based deliveries

When asked about home-based births and women's decision to give birth at home in Somaliland, the TBA said that although women know that trained midwives can save their lives through their knowledge of hygiene, prevention of infection and medications, they still appreciated the TBA for giving them privacy and care that is non-intrusive to their wishes. TBA stated that Somaliland women want to choose for themselves and accept the consequences of their choices. TBA felt that one aspect

Table 3 Demographic characteristics of the participants

Participant characteristics	Frequency=24
Gender	
Male	0
Female	24
Age	
20–29 years	1
30–39 years	9
40–50 years	14
Marital status	
Married	12
Divorced	2
Widowed	10
Profession	
TBA	22
TBA (training for midwifery)	2
Educational level	
Never gone to school	14
Primary	4
Secondary	4
University	2
Region	
Awdal	4
Jeex	4
Saxil	4
Dheer	4
Sool	4
Sanaag	4
Circumciser	
Yes	20
No	4
Years of experience	
0–10	2
10–20	8
20 and over	14
Connected to facility	
Yes	8
No	16
Total	24

TBA, traditional birth attendant.

of choosing for themselves was the home environment and given that trained midwives do not come to women's homes, this gives TBA an advantage over trained midwives. One TBA said, *"Women prefer us just because we have personal knowledge with them, and we give them respect and kindness. I am not saying we don't care about hygiene; we do, without it nothing can be done. But women appreciate and recognize our work because we come to them."* (TBA 22)

Poverty was another reason for women to avoid health facility delivery. Women and their families could not afford the cost of transport, treatment and medications. A TBA said, *"One of the main reasons for mothers to choose to give birth at home is financial reasons. A lot of these families can't afford to go to a hospital, but we take whatever they can give."* (TBA 3)

Some TBAs explained that after connecting with health facilities, some mothers still preferred to deliver at home and the TBAs chose to support and assist these women. Another TBA said, *"Most pregnant women are now connected to their local health care facilities, so the community's need for TBA has diminished rapidly in the capital city. But if I meet a mother who is in need of urgent care to deliver a baby, I will deliver the baby myself."* (TBA 7)

The TBA explained that when they assist a home-based birth, they pray for the best, yet the outcome is often adverse. One informant shared, *"I referred a woman after a home delivery with severe bleeding. I took her to the hospital in a car. Unfortunately, the doctor did not manage to stop the bleeding. She passed away with postpartum haemorrhage."* (TBA 5)

The TBA repeatedly explained that a deviation from the normal progress of labour was also difficult for them. They said that all they could do was wait for the woman to want to push, and if this was her first child and she had FGM/C pharaonic type, it might take time. They learnt to wait until they felt the baby's hair with one finger. They used herbal remedies to support women with most types of complications at home. One main reason for this was that women prefer to try herbal remedies before going to the healthcare facility.

Through TBAs' closeness with women in the community, they were also informed about any women who experienced early pregnancy complications. In some instances, it was possible for them to transfer a woman to a healthcare facility and receive treatment. One TBA shared: *"One day, a woman told me that there is a girl lying at home who had a miscarriage, and she has been sick for a while, and her husband didn't come, and when she asked him money to go to a doctor, he refused to give her any money. We transferred her to the nearest health facility; the doctor gave her fluids and the bleeding stopped."* (TBA 9)

Informants shared that they not only provided healthcare-related services in the community but also talked extensively about being a resource in the social system of their community: *"We often raise and collect money and food if there are families that need it. For example, if there is a mother who just gave birth and is in need, we bring her food and other people help her with the house chores until she gets better that is the only thing. We are great when we stand together in time of need."* (TBA 1)

The TBA shared how they have long had a function and role in being circumcisers. They explained that this was the norm and expectations of the community. Their reason for being circumcisers was that FGM/C is a strong cultural practice very connected with religion. They said that they, as young girls, had endured it, and given that they were dealing with women's defibulation during delivery, they were also thought to be the best person to circumcise girls. One TBA said, *"I've been a circumciser for 17 years. At first, I started with 'gudniinka fircooninga'* infibulation *and my daily routine still involves both conducting home-births and circumcision." (TBA 12)*

Being circumcisers meant another form of income for them. Families celebrated their daughter's circumcision, and it was also an important social group event in the community. Every few weeks, they would perform circumcision on a group of girls. One TBA said, *"'gudniinka fircooninga'* infibulation *is my source of income and when something is your source of income you can never say something bad about it"* (TBA 22).

When the public healthcare authorities introduced TBA into the health facilities to work with the midwives, an unintended consequence was that their function as circumcisers was also transferred to the healthcare facilities.

TBA transition to community mobilisers

TBAs' functions and roles in the community

The TBAs explained they had been travelling to villages beyond the mountain area with their water and food on foot to perform circumcision. While doing these outreach activities, they also responded to women's needs for support during childbirth, assisted in any early pregnancy complications and advised people with issues related to fertility. In rural and hard-to-reach areas, people grew up with TBA being central in giving health advice and performing healthcare-related services.

The respondents explained how they were the perfect agents to reach out to the community, understanding their needs and delivering health messages that would be accepted by their communities: *"As a TBA, the most important thing for my work is that the community trusts me. It's easier for me to do my job and fulfil my obligations, as I have already built a trust."* (TBA 4)

The TBA shared that the MoHD and non-governmental organisations (NGOs) have focused on educating TBA as community health workers trained in providing health messages to their communities and villages to reach out and give health advice to the local people. These health messages target information to eradicate FGM/C and promote healthy eating for pregnant mothers, advise on child spacing and encourage pregnant women to deliver at healthcare facilities. They explained that these topics are sensitive and require time and trust, and TBAs have the time and are trusted by the community related to health matters. They have built trusting relationships with fathers and religious leaders and organised outreach activities in villages to talk to families about ending FGM/C and the use of family planning methods to space out pregnancies. They explained that they knew how to convey the message best due to the already established trust. However, they are not paid permanently for their work, as these activities depend on donor funding.

One TBA explained, *"Recently we were eight traditional midwives and worked together to raise awareness of the community for a few weeks against* '*gudniinka fircooninga'* infibulation *and discussed with young girls and gave them advice about family planning and how to take care of their babies. We were mobile and had a great time talking and starting discussions with the homes. Also, if we saw anyone that needed medical help, we referred them to the nearest health facilities."* (TBA 14)

TBA in transitioning to become the link between the community and the healthcare system

TBA transition from home-based function to facility-based function

TBAs were connected to the MCH throughout the country wherever possible by health authorities without regulation or clearly documented rules and responsibilities. The limitation for this was the lack of frequent and equal funding in the regions. TBAs were trained by midwives on risk signs during pregnancy and how to assist midwives in the MCHs with basic midwifery care procedures and newborn care. Other groups of TBA were linked with the MCHs and compensated economically when they referred women from the communities to the MCHs depending on NGO funding. The informants living in the rural area far from the healthcare facility were only referrers, whereas those living near the MCHs were included in the staff of the MCH. The TBA said, *"A midwife who was the head of MCH assisted me and twenty other women with training and practical skills. We learned a lot during our time with MCH. We found out that it is good for mothers to give birth in a health facility where they have access to all necessary resources and medical equipment."* (TBA 10)

Most midwives were very respectful of the TBA and welcomed them into the MCH working environment and supported this transition: *"Yes, midwives recognize our work, support us frequently, we work together. I come to work early and before any of them do so, they appreciate my dedication, experience, and often ask me for advice but without payment. I appreciate and respect them for everything they do."* (TBA 6)

Some TBAs explained that not all relationships with midwives were positive and this was due to age differences, with the younger midwives not respecting the TBAs' long experience and the TBAs not accepting being directed in the health facility by a younger midwife.

One TBA stated, *"Well, the midwife is more educated than I am but other than that I don't think she is better than me with anything else as I said some of the midwives are welcoming and accepting… and other they don't like us. I tell them first I know that you are educated, but I have skills that Allah taught me and Allah is supporting this mother and her child. The most important thing for you and me is to save the mother and her child."* (TBA13)

Some TBAs who wanted to work at the MCH with midwives also continued into further education and became trained midwives, as they respected the knowledge and skills trained midwives had acquired through formal education. One TBA said: *"I was a TBA first, but now I'm a midwife student at Golis University to gain more knowledge, improve my skills and certify myself as a qualified midwife"*. (TBA 20)

The respondents who received training from MoHD to support the midwives at the healthcare facilities explained that training and expertise gave them confidence. The TBA explained that they would receive discrete payments while using unauthorised medications from the

healthcare facility to circumcise because mothers would come to the health facilities, given that the TBA would be there.

A TBA stated, *"The Ministry of Health recruited me to the hospital, especially maternity ward as cleaner because I was an active worker and to help the two midwives who were working at that ward, after a while I learnt how they were doing everything, how to deliver and how to inject then I started my journey circumcising at the facility for payment."* (TBA 23)

TBAs' future needs and preferences in relation to their functions and roles

The TBA in this study expressed that they demand respect from health authorities and the community to recognise that they were a resource base.

One TBA expressed, *"I would like to add that the Ministry of Health needs to recognize TBA women. We need the chance to improve our knowledge and become part of health workers."* (TBA 16)

The TBA did not want to be left behind. They advised their daughters to enter midwifery education and to work within private and public healthcare facilities to ensure their survival. The TBAs provide services in the communities without knowledge, medication and equipment. TBAs suggested that they require training and support until more midwives are available in the eastern region.

DISCUSSION

This study reveals a significant shift in the role of TBA in Somaliland. Historically, TBAs were primary caregivers for pregnancy, childbirth and FGM/C within communities. However, they are increasingly transitioning from direct providers of traditional practices to intermediaries linking women and families with formal healthcare services. This transition reflects their enduring trust within communities and their potential as vital connectors promoting access to SHP and institutional care. Despite this evolving role, TBAs continue to assist with home deliveries and FGM/C, a practice they find difficult to abandon mainly due to financial dependence. Our findings echo previous research reporting high prevalence of FGM/C in Somaliland, with a noted decrease in urban areas due to awareness campaigns.[25] However, the medicalisation of FGM/C where trained health professionals perform the procedure has emerged as a concerning trend. TBAs' introduction of circumcision practices to healthcare workers has inadvertently shifted FGM/C into health facilities. This shift is partly driven by community perceptions that medicalised circumcision is safer, underscoring the urgent need for policy and training interventions.[26 27] The MoHD is currently developing policies to counteract this trend, yet further research is needed to understand its impact on women's sexual and reproductive health.

TBA also perceive themselves as pioneers who paved the way for midwifery services and demand recognition for their role in maternal health. While past studies suggested that referring women to health facilities might reduce TBAs' influence and income,[25] our findings indicate that many TBAs have embraced collaboration with SHP and adapted to being part of the healthcare system. Training TBA to act as companions to women during pregnancy and childbirth, while providing respectful support and essential health education within health facilities, not only builds on their established community trust but also enhances continuity of care. This approach aligns with the ICM essential competencies for midwifery practice[8] and supports the WHO's position on transitioning to midwifery-led models of care.[7] It optimises outcomes for women and newborns by ensuring culturally acceptable and woman-centred care. Integrating TBA into formal systems in a structured and supportive way not only strengthens health system responsiveness but also acknowledges the critical role midwives play in extending the reach of essential services. This reinforces the value of collaborative, team-based care in improving maternal and newborn health outcomes across diverse and resource-constrained settings. This can reduce the gap between SHP and TBA and allow TBA to be integrated into the healthcare system as promoters of facility-based birth and act as companions for women, while also providing them with health messages. Evidence from Somaliland supports this approach.[20 28 29] Training TBAs and linking them to MCH centres resulted in a 300% increase in facility births within participating centres. TBAs are highly respected community members and, if effectively integrated and compensated, can serve as valuable agents for promoting safe maternity care and health awareness, especially in rural areas where education and trust in formal healthcare remain limited.[30]

Our study results show that through the voices of TBAs, women need to be connected within their homes and that this is one of TBAs' strengths. Target one focuses on achieving at least four antenatal visits and up to three postnatal visits within 2 days of delivery to reduce maternal mortality, which, for most women in Somaliland, can only be achieved through home visits.[28] Previous studies have shown that linking TBA to the healthcare system can increase not only health facility delivery but also antenatal and postnatal visits.[3 20] Using TBAs to establish trusting relationships with communities can help improve facility uptake and women's access to SHP. TBAs can be mobilised for referral purposes, similar to the role played by Public Health Midwives in Sri Lanka, especially in communities facing acute shortages of SHP, such as midwives.[29] They can play an important role in helping women feel supported and retain reproductive autonomy while in the health facilities. For TBA to assume this role, they need specific training for those employed at health facilities, utilising them to promote evidence-based practices after childbirth, such as skin-to-skin contact and breastfeeding.[1 31]

In a qualitative study, the goal is not statistical generalisation but rather to gain deep, contextual insights into participants' lived experiences. Having said that, it would

have been beneficial to share the results with the study participant and allow them to comment on the results for a stronger result and to achieve triangulation. While 24 respondents—four TBAs from each of Somaliland's six regions—do not statistically represent the entire country as in a quantitative study, they provide a diverse and regionally balanced sample that allows for rich understanding of variations and commonalities in TBA roles across different geographic and social contexts. The selection ensures voices from multiple regions are included, supporting a broader qualitative exploration of past and current TBA practices in Somaliland.'

Implications and Recommendations

These findings are intended to inform healthcare practitioners, programme planners and policymakers working to improve maternal and newborn health in resource-limited settings. In the pursuit of universal health coverage and the goal of delivering high-quality, equitable care for all, leveraging TBA as part of a broader midwifery-led care model offers a cost-effective strategy in the Somaliland context. Structured, standardised training programmes and clear role definitions are needed to formalise TBA integration within maternity services. Additionally, ethical and professional conduct training for TBA working in health facilities could help reduce harmful practices and improve service quality.

CONCLUSION

This study offers valuable insights into the role of TBAs from their own unique perspectives of being a bridge between the community and the healthcare system. Understanding the evolving roles and perspectives of TBAs is vital for improving maternal and newborn health outcomes, particularly in resource-limited settings. TBAs, through their trusted relationships with communities, can improve women's access to skilled health professionals by encouraging facility-based care and acting as referral agents. Strengthened collaboration between TBA and SHP has hence the potential to reduce maternal morbidity and mortality in low-resource settings. Further research is needed to map and support this transition.

Acknowledgements We want to acknowledge all who made this study possible, in particular the TBA in Somaliland.

Collaborators Not applicable.

Contributors All authors contributed to data collection, analysis and manuscript writing. MK-A, FO and JAE planned the study. Data collection was carried out by JAE and AE. The analysis was performed collaboratively by JAE, AE, FO, KE and MK-A. JAE submitted the manuscript. Revisions were made by JAE and KE. MK-A acted as guarantor for the overall work. All authors have read and approved the final manuscript.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient and public involvement Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

Patient consent for publication Consent obtained directly from patient(s)

Ethics approval All participants provided informed consent through thumbprint or signature, with verbal explanation given in their preferred language to ensure understanding, especially considering potential literacy limitations. Confidentiality was maintained by de-identifying data and securely storing recordings and transcripts. Given the sensitivity of topics such as FGM/C, interviews were conducted privately and respectfully. The study was planned and conducted in accordance with the Helsinki Declaration[25] of research ethical principles. The MoHD approved the study (Dnr: Mo/HD/00) and facilitated a request letter to the regional health officers. The Ethics Committee of the University of Hargeisa gave ethical approval (Dr: CS/41105/18).

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement All data relevant to the study are included in the article or uploaded as supplementary information. Not Applicable.

ORCID iDs

Jama Ali Egal https://orcid.org/0000-0002-8533-9905
Fatumo Osman https://orcid.org/0000-0002-0038-9402

REFERENCES

1 Sibley LM, Sipe TA, Barry D. Traditional birth attendant training for improving health behaviours and pregnancy outcomes. *Cochrane Database Syst Rev* 2012;2012:CD005460.
2 Sibley LM, Sipe TA, Brown CM, *et al*. Traditional birth attendant training for improving health behaviours and pregnancy outcomes. *Cochrane Database Syst Rev* 2007;2007:CD005460.
3 WHO, UNFPA, Unicef. Traditional Birth Attendants: A Joint WHO/UNFPA/UNICEF Statement. Geneva: World Health Organization, 1992.
4 World Helath Organization. Definition of Skilled Health Personnel Providing Care during Childbirth: The 2018 Joint Statement by WHO. FIGO and IPA Geneva: UNFPA, UNICEF, ICM, ICN, 2018.
5 Kruske S, Barclay L. Effect of shifting policies on traditional birth attendant training. *J Midwifery Womens Health* 2004;49:306–11.
6 Scarf VL, Rossiter C, Vedam S, *et al*. Maternal and perinatal outcomes by planned place of birth among women with low-risk pregnancies in high-income countries: A systematic review and meta-analysis. *Midwifery* 2018;62:240–55.
7 World Helath Organization (WHO). In: *Transitioning to midwifery models of care: global position paper*. Geneva: Licence: CC BY-NC-SA 3.0 IGO, 2024.
8 Interntional Confederation of Midwives (ICM). ICM Essential Competencies for Midwifery Practice The Hague: International Confederation of Midwives; Licence: CC BY-NC-SA 4.0. 2024.
9 Uninted Nation Population Fund (UNFPA). The State of the World's Midwifery 2014. Geneva: United Nations Population Fund, 2014.
10 Renfrew MJ, McFadden A, Bastos MH, *et al*. Midwifery and quality care: findings from a new evidence-informed framework for maternal and newborn care. *The Lancet* 2014;384:1129–45.
11 Sandall J, Fernandez Turienzo C, Devane D, *et al*. Midwife continuity of care models versus other models of care for childbearing women. *Cochrane Database Syst Rev* 2024;4:CD004667.
12 Central Statistics Department MoPaND, Somaliland Governmen. The 2020 somaliland health and demographic survey. 2020.
13 Ministry of Health (MoH). *Ministry of health annual report hargeisa somaliland*. 2016.
14 Egal JA, Essa A, Yusuf R, *et al*. A lack of reproductive agency in facility-based births makes home births a first choice regardless of potential risks and medical needs-a qualitative study among multiparous women in Somaliland. *Glob Health Action* 2022;15:2054110.
15 Abdillahi HA, Hassan KA, Kiruja J, *et al*. A mixed-methods study of maternal near miss and death after emergency cesarean delivery at a referral hospital in Somaliland. *Int J Gynaecol Obstet* 2017;138:119–24.
16 Kiruja J, Osman F, Egal JA, *et al*. Maternal near-miss and death incidences - Frequencies, causes and the referral chain in Somaliland: A pilot study using the WHO near-miss approach. *Sex Reprod Healthc* 2017;12:30–6.

17 Kiruja J, Essén B, Erlandsson K, *et al*. Healthcare providers' experiences of comprehensive emergency obstetric care in Somaliland: An explorative study with focus on cesarean deliveries. *Sexual & Reproductive Healthcare* 2022;34:100768.
18 Berg RC, Underland V. The obstetric consequences of female genital mutilation/cutting: a systematic review and meta-analysis. *Obstet Gynecol Int* 2013;2013:496564.
19 International Confederation of Midwives (ICM). Essential competencies for midwifery practice. 2018.
20 Erlandsson K, Osman F, Hatakka M, *et al*. Evaluation of an online master's programme in Somaliland. A phenomenographic study on the experience of professional and personal development among midwifery faculty. *Nurse Educ Pract* 2017;25:96–103.
21 Ojo OO, Hersi OO, Falobi AA, *et al*. Assessment of the capacity of health facilities in preventing and managing non-communicable diseases in selected regions of Somaliland. *BMC Health Serv Res* 2025;25:744.
22 Creswell JW, Plano Clark VLD, Research CMM. 3rd edn. Thousand Oaks, CA: SAGE, 2018.
23 Sinclair M. The translation of the childbirth self-efficacy inventory into Arabic. *Evid Based Midwifery* 2012;2012:45–9.
24 Braun V, Clarke V. Conceptual and design thinking for thematic analysis. *Qualitative Psychology* 2022;9:3–26.
25 Egal JA, Kiruja J, Litorp H, *et al*. Incidence and causes of severe maternal outcomes in Somaliland using the sub-Saharan Africa maternal near-miss criteria: A prospective cross-sectional study in a national referral hospital. *Int J Gynaecol Obstet* 2022;159:856–64.
26 Yussuf M, Matanda DJ, Powell RA. Exploring the capacity of the Somaliland healthcare system to manage female genital mutilation / cutting-related complications and prevent the medicalization of the practice: a cross-sectional study. *BMC Health Serv Res* 2020;20:200.
27 Doucet M-H, Pallitto C, Groleau D. Understanding the motivations of health-care providers in performing female genital mutilation: an integrative review of the literature. *Reprod Health* 2017;14:46.
28 WHO global meeting to accelerate progress on SDG target 3.4 on noncommunicable diseases and mental health. *East Mediterr Health J* 2021;27:524–5.
29 Yale School of Public Health. Mobilising communities prior to healthcare interventions: reflections on the role of public health midwives working with vulnerable communities of sri lanka. 2018.
30 Pyone T, Adaji S, Madaj B, *et al*. Changing the role of the traditional birth attendant in Somaliland. *Int J Gynaecol Obstet* 2014;127:41–6.
31 Wilunda C, Dall'Oglio G, Scanagatta C, *et al*. Changing the role of traditional birth attendants in Yirol West County, South Sudan. *PLoS One* 2017;12:e0185726.