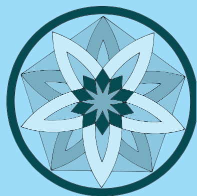
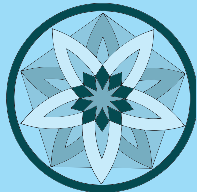
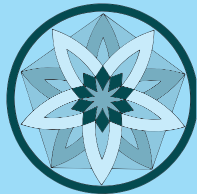
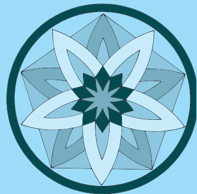
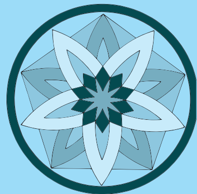
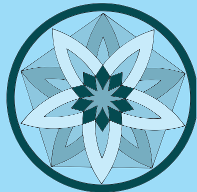
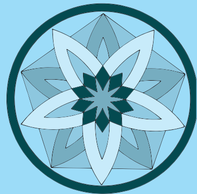
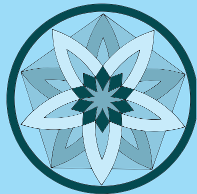
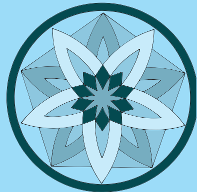
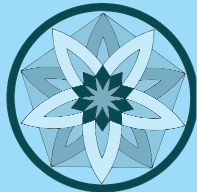

Place of Delivery: Perceptions, Tensions, and Experiences

Results from a Study in Baringo, Kisumu, Migori, Nakuru, Samburu, and Turkana Counties, Kenya

DHS Qualitative Research Studies 22

November 2018

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DHS Qualitative Research Studies No. 22

Place of Delivery: Perceptions, Tensions, and Experiences

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Susan Pietrzyk,[1] Lwendo Moonzwe,[1] Jacinta Nzinga,[2] Ambrose Agweyu,[2]
Kerry L. D. MacQuarrie,[3] Debra Prosnitz,[1] Allison Schmale[1]

ICF
Rockville, Maryland, USA

Health Strat
Nairobi, Kenya

November 2018

[1] The DHS Program, ICF; [2] Health Strat; [3] The DHS Program, Avenir Health

Corresponding author: Susan Pietrzyk, International Health and Development, ICF, 530 Gaither Road, Suite 500, Rockville, MD 20850, USA; phone: +1 301-572-0806; fax: +1 301-572-0999; email: susan.pietrzyk@icf.com

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Additional information about the 2014 KDHS may be obtained from the Kenya National Bureau of Statistics (KNBS), P.O. Box 30266-00100 GPO, Nairobi, Kenya; telephone (Nairobi): 3317586/8, 3317612/22, 3317623, 3317651; fax: 3315977; email: directorgeneral@knbs.or.ke, info@knbs.or.ke; website: www.knbs.or.ke.

The DHS Program assists worldwide in the collection and use of data to monitor and evaluate population, health, and nutrition programs. Additional information about The DHS Program can be obtained from ICF, 530 Gaither Road, Suite 500, Rockville, MD 20850 USA; telephone: +1 301-572-0200, fax: +1 301-572-0999, email: info@DHSprogram.com, internet: www.DHSprogram.com.

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PREFACE

The Demographic and Health Surveys (DHS) Program is one of the principal sources of international data on fertility, family planning, maternal and child health, nutrition, mortality, environmental health, HIV/AIDS, malaria, and provision of health services.

Occasionally DHS is able to supplement surveys with qualitative data collection and analysis to answer specific questions that are better explored using qualitative or mixed method approaches. Such research can also help clarify the interpretation of some complex indicators and improve understanding of measurement issues in DHS surveys. Results from these qualitative studies are made available in the DHS Qualitative Research Studies series.

The topics in this series are selected by The DHS Program in consultation with the U.S. Agency for International Development.

It is hoped that the DHS Qualitative Research Studies will be useful to researchers, policymakers, and survey specialists, particularly those engaged in work in low- and middle-income countries.

Sunita Kishor
Director, The DHS Program

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The analysis and writing in this report improved through the thoughtful review provided by Anne Siegle (ICF), Hannah Jahnke (Department of Anthropology, University of North Carolina Chapel Hill), and Lindsay Mallick (Avenir Health).

A final and important note of thanks goes to the 303 men and women who volunteered their time to be study participants. Without waver, the study participants exhibited kindness, including welcoming our team members into their homes, while also sharing their experiences and providing invaluable insights about maternal health matters in Kenya.

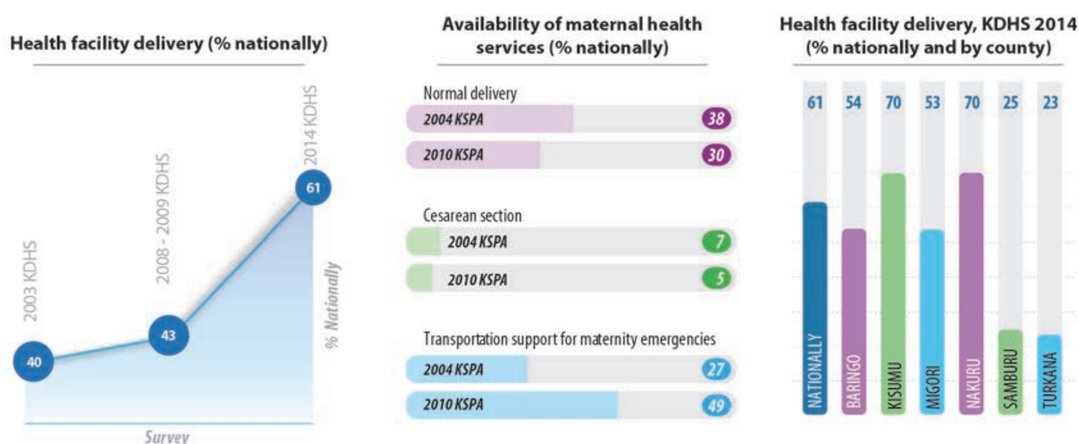
ABSTRACT

The 2014 Kenya Demographic and Health Survey (2014 KDHS) was the first national survey in Kenya to produce county-level indicator estimates. Data from this survey indicate that, nationally, 61% of live births were delivered in a health facility, but with considerable variation across Kenya's 47 counties. The present study—one of three studies funded by the U.S. Agency for International Development Mission in Kenya (USAID/Kenya) to complement the 2014 KDHS—analyzed qualitative data collected from participants in Baringo, Kisumu, Migori, Nakuru, Samburu, and Turkana Counties. The study included 24 focus group discussions, 24 key informant interviews, and 60 in-depth interviews to examine individual and contextual factors that influence women's actions around place of delivery. The findings indicate that women do not always choose their place of delivery. Further, simply grouping deliveries and women into two categories—health facility and home—risks missing the details and nuances concerning the many factors that influence place of delivery. Data from the study suggest that women's actions and contextual factors pertaining to place of delivery combine with a wide range of perceptions about health services and health facilities, tensions related to cultural beliefs and practices, and experiences and feelings during pregnancy to affect where women deliver. The study reaches a number of conclusions, for each of the research questions, and makes recommendations for improving the quality of and accessibility to health care and also finding ways for women and their partners to make more use of health facilities during pregnancy and delivery.

ACRONYMS AND ABBREVIATIONS

AIDS	acquired immunodeficiency syndrome
ANC	antenatal care
CDH	County Directors of Health
CHV	community health volunteer
CRHC	County Reproductive Health Coordinators
DHS	Demographic and Health Survey
HMIS	Health Management Information System
IRB	Institutional Review Board
KDHS	Kenya Demographic and Health Survey
KMHFL	Kenya Master Health Facility List
KSPA	Kenya Service Provision Assessment
MCH	maternal and child health
MDG	Millennium Development Goal
MoH	Ministry of Health
PMTCT	prevention of mother-to-child transmission
PNC	postnatal care
NHIF	National Hospital Insurance Fund
SBA	skilled birth attendance, skilled birth attendant
TBA	traditional birth attendant
SPA	Service Provision Assessment
USAID	U.S. Agency for International Development

1 INTRODUCTION AND BACKGROUND



The DHS Program has conducted six Demographic and Health Surveys in Kenya since 1989 and three Service Provision Assessment (SPA) surveys since 1999. The 2014 Kenya Demographic and Health Survey (2014 KDHS) is the first national survey to produce estimates of key indicators at the county level, to correspond to the devolution of health services to county governments. Guided by these and other data, the U.S. Agency for International Development Mission in Kenya (USAID/Kenya) has identified 10 Maternal and Child Health (MCH) high-priority counties: Baringo, Kakamega, Kilifi, Kisumu, Kitui, Migori, Nairobi (informal settlements), Nakuru, Samburu, and Turkana (see Chapter 2, Figure 2). Following the 2014 KDHS, The DHS Program was asked to undertake further analysis activities, as described below:

- **Maternal Care-Seeking in High-Priority Counties.** This study compares univariate levels of multiple maternal care indicators among 10 USAID/Kenya MCH high-priority counties and with the national average to describe regional disparities.
- **Determinants of Maternal Care-Seeking.** This study is a theoretically driven, multivariate regression model for (a) antenatal care (ANC), (b) health facility delivery, and (c) postnatal care (PNC). Sociodemographic characteristics, fertility risk, predisposing, and enabling factors are included in models for all three outcomes.
- **Qualitative Study in Selected High-Priority Counties.** This study examines the pregnancy-to-delivery continuum broadly and place of delivery specifically through three research questions:

  1. How do pregnant women make and implement choices about where to deliver?
  2. Why do pregnant women choose not to deliver at health facilities, even when such facilities appear to be available?
  3. What individual factors and contextual factors beyond individual agency influence women's behavior with regard to where they deliver?

  Given time and budget limitations, 6 of the 10 high-priority counties were purposefully selected for the study—Baringo, Kisumu, Migori, Nakuru, Samburu, and Turkana Counties.

This report pertains only to the third further analysis activity, the qualitative study in selected high-priority counties in Kenya. This first chapter provides an overview of the contextual landscape in Kenya and recent maternal health data and literature. The review casts a broad net and aims to draw out ways the Government of Kenya, development partners, researchers, and health care practitioners and providers have over time given substantial attention to improving the country's maternal health policies, services, and outcomes.

Chapter 2 outlines the design and methods for the study. The remaining chapters present the findings of the study. More specifically, Chapter 3 focuses on the characteristics of the participants, including demographic information about the 60 in-depth interview participants. Chapter 4 provides a foundational and contextual starting point. The chapter begins with a county-by-county lens and presents county-level quantitative metrics as well as women's narratives of delivery. The second half of the chapter moves to consider the data across the six counties collectively and includes findings that highlight the context in which women experience the continuum from pregnancy to delivery; notably, the latter half of Chapter 4 includes analysis of the male-only focus group discussions and geographic, transport, and financial challenges women face.

Chapters 5, 6, and 7 continue to consider the data across all six counties collectively. Each chapter examines a specific theme in relation to the pregnancy-to-delivery continuum, with a focus on perceptions (about health services and health facilities), tensions (surrounding cultural beliefs and practices), and experiences (relating to feelings during pregnancy), respectively. Chapter 8 provides conclusions and recommendations.

1.1 Sociopolitical Context in Kenya

County devolution

In August 2010 the new Constitution of Kenya created 47 counties, introduced new checks and balances to the executive branch, and devolved power and resources to the county level (Laws of Devolution 2018c). The main purpose of the devolution was to decentralize power, resources, and representation to a more local level. In response, the Kenyan Parliament has instituted laws to create strategies for the implementation framework and adoption of achieving devolution (Laws of Devolution 2018c). This new constitution allows for local county governors to be directly elected by the people and created a bicameral parliament with a Senate and National Assembly (CIA World Factbook 2018b). The new constitution is meant to encourage the participation of all Kenyans in decision-making processes and promote democratic and accountable exercise of power. It also emphasizes national unity by recognizing diversity (Kimanthi 2017).

The 2010 Constitution stipulates that all Kenyans are entitled to the "highest attainable standards of health" (Kimanthi 2017) inclusive of the right of every child to basic nutrition, shelter, and health care; affirmative action for minorities and marginalized groups, designed to improve their access to water, health services, and infrastructure; and equal reproductive health care (Kimanthi 2017).

County devolution aims to promote citizen participation, county autonomy, and quick decision-making for resource mobilization and management issues. There are major challenges to attaining these goals, however, including capacity gaps, human resource deficiency, lack of legal and institutional infrastructure, corruption, and tenuous relations with the national government. These challenges have hindered the development and effectiveness of health care, to the extent that progress has regressed and there are poorer outcomes on some health indicators (Kimanthi 2017).

County devolution and health care

Under the devolved county structure, the health system is organized on two levels: national Ministry of Health (MoH) and national referral health facilities, and county (National Council for Law Reporting 2010). The core function of the MoH is to support the attainment of health goals by providing appropriate strategic frameworks and implementation guidance for health interventions. The county health system focuses on budgeting and allocating resources and delivery of preventive, health promotion, and curative services. Ensuring sustainable financing for health services remains a challenge with the complexity of sharing resources among 47 counties and the national government. Most Kenyan counties have struggled with allocation of resources for health, retention of human resources, procurement and supply chain management, and planning and implementation of services (Tama et al. 2017). The national health management information system (HMIS) continues to face challenges, limiting the ability of programs to monitor progress toward health sector targets (Kihuba et al. 2014).

Delivery of health services in Kenya

Level 1: Community services focused on creating appropriate demand for services

Level 2: Primary health services comprising all dispensaries, health centers, and maternity homes in public, faith-based, and private sectors

Level 3: County referral services, including all hospitals, serving as referral facilities for primary health services

Level 4: National referral services to provide specialized services, including medical care, reference laboratory support, blood transfusion services, and research

County authorities are responsible for providing services in levels one to three.

National authorities are responsible for providing services in level four.

Source: MoH 2014.

In 2013, the government announced the abolition of user fees for maternity services at all levels of care in the public health facilities through output-based reimbursements to public facilities based on quarterly reports on numbers of maternal deliveries. This policy aimed at reducing maternal and neonatal deaths in an effort to achieve the Millennium Development Goal targets. Evaluations describing experiences from this policy have reported mixed findings, with increased health utilization on one hand and inadequate supplies and staff to meet the additional workload resulting in demotivation among health workers on the other hand (Wamwala 2017; Njunguna et al. 2017).

In October 2016, the Government of Kenya transitioned the free maternity services program from the Ministry of Health to the National Hospital Insurance Fund (NHIF). The NHIF was established in 1967 as a Kenya Government state corporation with the mandate to provide health insurance to Kenyans over age 18. This decision was made to align the free maternity care program with the wider national health policy framework aimed at elimination of out-of-pocket payments for health services through social health insurance (MoH 2014). The revised free maternity policy, commonly referred to as *Linda Mama*, extends service access beyond public facilities to include low-cost private and faith-based facilities.

Ethnic and tribal context

Kenyan Tribe	Percent of Total Population
Kikuyu	22
Luhya	14
Luo	13
Kalenjin	12
Kamba	11
Kisii	6
Meru	6
Other African/tribes	15
Non-African (Asian, European, and Arab)	1

Source: Kenya Information Guide 2015b.

Kenya is an ethnically diverse country, with three ethnic groups encompassing 44 nationally recognized tribes (Dahir 2017). The Bantu ethnic group is the largest, comprising about 70% of the country's population, and occupying about 30% of the land, mainly in the coastal, central, western, and eastern regions. The Kikuyu belong to the Bantu ethnic group and are the largest single tribe in Kenya. Other tribes in the Bantu ethnic group include: Embu, Meru, Luhya, Kamba, Kisii, Swahili, Taita, and Mijikeda. Rural Bantus tend to be agriculturists, farming cash crops like coffee, tea, maize, beans, rice, and sugar (Kenya Information Guide 2015b; CIA World Factbook 2018b).

The second ethnic group is the Nilotes (or Nilo-Saharan), living in the Rift Valley region near Lake Victoria. Nilote tribes include Luo, Maasai, Samburu, Turkana, and Kalenjin. The Luo tend to practice fishing; the Maasai, Samburu, and Turkana tend to be nomadic pastoralists, and the Kalenjin tend to practice both pastoralism and agriculture (Kenya Information Guide 2015a; CIA World Factbook 2018b).

The third ethnic group, the Cushites or Afro-Asiatic, live in the more semi-arid and northern parts of Kenya, including the east side of Lake Turkana to the north of Kenya to the Indian Ocean. Cushite tribes include the Somali, Rendile, Borana, and Orama. The Cushite tribes tend to be nomadic pastoralists and keep herds of cattle, sheep, camels, and goats (Kenya Information Guide 2015a; CIA World Factbook 2018b).

There is a history of tribal tensions in Kenya, dating back to precolonial times. Much of the tension revolved around land and increasing British presence. At the end of colonialism in 1963, tribes believed they owned the land they occupied and thought of those who were not of their tribe as outsiders. This caused tribal conflicts over land. With population growth, limited natural resources, and climate change, arguments have intensified. In addition to land disputes, the government infrastructure has favored those in power, marginalizing smaller groups and groups in isolated counties. These two types of conflicts are often intertwined, where those in power tend to favor their tribal group with better land, which can infringe on indigenous people's land (Kawegah 2017).

Tribalism continues to affect Kenyan politics to date, where tribal loyalties influence power and resources. This has perpetuated regional inequalities, where communities not in power are continually marginalized. This tribal context has also created an environment conducive to corruption, and promotes development strategies based on false presumptions regarding tribes and ethnic backgrounds (Gathara 2018).

The official languages of Kenya are English and Swahili; however, there are roughly 66 other languages spoken in the county. Linguistic diversity is closely related to Kenya's 44 tribes. The most commonly spoken tribal languages are Kikuyu, Luhya, Dholuo, and Kamba, followed by Ekegusii, Kimmiiru, and Kalenjin (Kenya Information Guide 2015a).

1.2 Maternal and Child Health Globally and in Kenya

Globally, an estimated 289,000 women of reproductive age die of maternal causes each year. Over 80% of these deaths are due to complications during childbirth and the postpartum period including hemorrhage, obstructed labor, hypertensive disorders (e.g., severe preeclampsia or eclampsia), complications related to abortion, and postpartum sepsis (WHO 2014). Skilled birth attendance (SBA) at health facilities equipped to handle these complications is crucial for ensuring maternal survival. While Kenya has made progress in improving maternal health services in the last decade, less than two-thirds of births are delivered in a health facility. Results from the 2014 KDHS indicate a health facility delivery rate of 61% (KNBS 2015). It follows that there has been only a modest decline in the maternal mortality rate, from 488 deaths per 100,000 births in 2008 to 362 deaths per 100,000 births in 2014 (KNBS 2015).

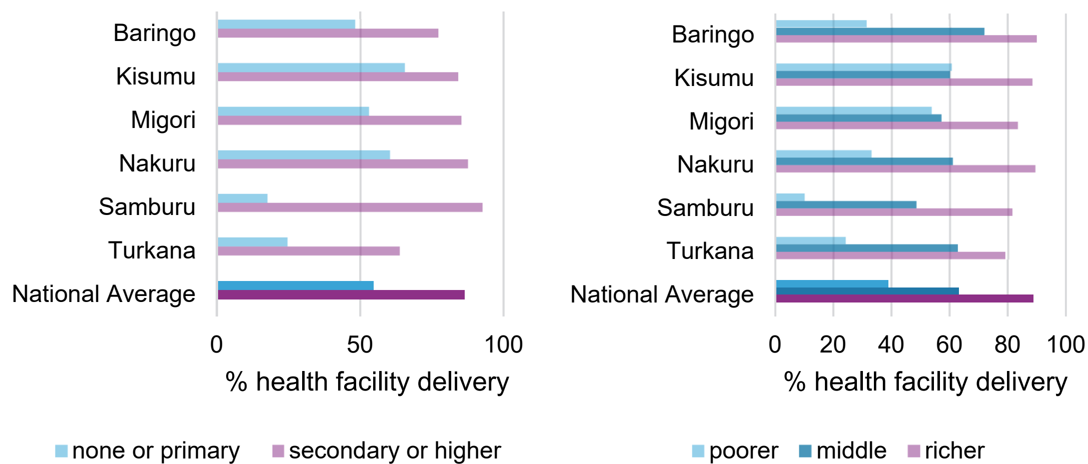
The 2014 KDHS was the first survey in Kenya to produce county-level estimates. These estimates show notable differences among counties in delivery with skilled birth attendance. The percentage of live births delivered in a health facility ranged from 18% in Wajir County to 93% in Kiambu County. The range in skilled assistance among the counties examined in this qualitative study is from 23% to 70%: Baringo (54%), Kisumu (70%), Migori (53%), Nakuru (70%), Samburu (25%), and Turkana (23%) (KNBS 2015) (see Figure 2 in Chapter 2 for a map of Kenya showing the location of these six counties). Reasons for these variations are not fully known, and greater understanding of the local factors that influence delivery with skilled birth assistance is vital to preventing maternal deaths (Gabrysch and Campbell 2009).

1.3 Factors and Inequities Impacting Health Facility Delivery

Sociocultural factors related to gendered power imbalances often create barriers to health facility delivery. The specific factors include lack of male involvement in maternal health planning; lack of birth plans; husband or head of household as the key decision-maker regarding place of delivery; and women's discomfort with male health providers (Wanjira et al. 2011; Kwambai et al. 2013; Mathulu et al. 2017; Nyandieka et al. 2016; Mason et al. 2015; Karanja et al. 2018). A 2012 study in Migori County identified three factors as significantly associated with health facility delivery: 1) women discussing the place of delivery with their male partner or husband, 2) deciding on the place of delivery with someone else, and 3) not having any experience of intimate partner violence during pregnancy or the postpartum period (Turan et al. 2012).

Multiple studies in Kenya have shown that women with higher levels of education are more likely to deliver in a health facility (Mbugua and MacQuarrie 2018a; Mokua 2014; Ono et al. 2013; Turan et al. 2012), as are women in higher wealth quintiles or women with a personal source of income (e.g., salaried employees) (Mbugua and MacQuarrie 2018a; Mokua 2014; Ono et al. 2013). Secondary analysis of the 2014 KDHS examined variation and sociodemographic inequities in maternal health indicators (Mbugua and MacQuarrie 2018b). As Figure 1 shows, inequities in education and wealth exist for the counties examined in this qualitative study. In Samburu County, for example, over 80% of women with secondary or higher education delivered in a health facility compared with under 20% of women with only primary school or no education. In all six counties at least 80% of women in the highest of the three wealth groups (richer) delivered at a facility. Rates of health facility delivery for women in the other two wealth groups (middle and poorer) surpass 60% only for those in the middle group in Baringo County.

Figure 1 Inequities in health facility delivery in relation to education and wealth



In addition to education and wealth, women's decision-making power is an important contributing factor to seeking maternal and child health care and delivering in a health facility. Nationally, over half (54%) of currently married women participate in four common household decisions, but only 39% are primary decision-makers about their own health care (KNBS 2015). In pastoralist communities such as among the Samburu, however, men commonly make decisions about health care for women (Caulfield et al. 2016). These factors play a role in maternity care and delivery, specifically. The 2014 KDHS found that access to ANC, SBA, and PNC all increased with women's participation in decision-making (KNBS 2015).

1.4 Health Facilities and Health Services in Kenya

Quality of care

In many parts of Kenya, women seeking maternal health care perceive and describe the quality of care as poor (Ng'anjo Phiri et al. 2014; Diamond-Smith et al. 2016). Women's perceptions of quality of care are often complicated by experiences of disrespect and abuse including humiliation, lack of confidentiality, care without consent, physical abuse, verbal abuse, neglect or abandonment, and detainment (for nonpayment) during maternity care (Abuya et al. 2015a; Abuya et al. 2015b; Karanja et al. 2018). A recent study in western Kenya reported that only 29% of women were provided with continuous support during labor and delivery (Afulani et al. 2018). Another study across four Kenyan sub-counties reported that 20% of women said they experienced some form of disrespect and abuse in maternity care (Abuya et al. 2015). Across these two studies, common concerns that women reported included health service providers abandoning women because of the large number of births occurring in the facility, and health service providers withholding information regarding treatments given to the women, on an assumption that the women were poor. Research has suggested higher degrees of abuse from health service providers toward adolescent mothers in the belief that they conceived too early (Warren et al. 2017). In addition, some studies have suggested that women with lower socioeconomic status and pastoralist women are prone to harsh treatment at health facilities and thus often avoid facility care for fear of bad treatment (Turan et al. 2012; Caulfield et al. 2016).

Maternal health and HIV

HIV prevalence in Kenya has decreased over the past 20 years, from 11% in 1996 to 6% in 2015. In 2016, an estimated 1.6 million people in Kenya were living with HIV, including 910,000 women (UNAIDS 2017; UNAIDS 2018). Over the last decade Kenya has integrated HIV testing, counselling, and treatment into maternal health services (Turan et al. 2012). In addition, HIV testing has become a routine part of ANC, while prevention of mother-to-child transmission (PMTCT) has lowered the incidence of HIV among newborns. Stigma and discrimination around HIV remain prevalent in Kenya, however, and carry over into maternal health practices (Turin et al. 2012). Often, HIV-positive pregnant women experience stigma on two levels, given the possible perception that they are putting their child's health at risk (Turan et al. 2012). Because it is thought to be most appropriate for women with HIV to give birth in a health facility, some women consider that health facility delivery presents a risk of being labelled as HIV-positive—sometimes incorrectly (Turan et al. 2008; Turan et al. 2011; Turan et al. 2012). This risk and the fear of unwanted disclosure of HIV status are only some of the HIV-related barriers to health facility delivery (Turan et al. 2008). Studies have found that women often anticipate negative reactions from their male partners if they test positive for HIV, and those who test HIV-positive are less likely to have favorable attitudes toward health facility delivery (Turan et al. 2008; Medema-Wijnveen et al. 2012). Medema-Wijnveen and colleagues (2012) reported that some women anticipated bad treatment by health providers if they tested HIV-positive. Turan and colleagues in a study in Kisumu found that women with unknown HIV status became targets of stigma and discriminatory practices during labor and delivery (Turan et al. 2008). Reasons for the stigma and discriminatory practices, as reported by health workers, included fear of HIV infection due to poor infection control at health facilities. Further, the health workers noted that protecting patient confidentiality was difficult given that PMTCT is provided in crowded settings (Turan et al. 2008).

1.5 Traditional Beliefs and Practices

Traditional birth practices

Use of herbs is common among traditional childbirth practices throughout Kenyan communities. During pregnancy, Marakwet women in western Kenya take herbs and drink sour milk mixed with cow's blood (Rono et al. 2018). Following birth, Samburu mothers are encouraged to drink cow's blood boiled with plant roots to induce vomiting and push out the afterbirth (Fratkin 1996). Traditional birth attendants (TBAs) on the coast of Kenya provide herbs and massage for abdominal pain or bleeding and to accelerate labor (Boerma and Baya 1990). In Machakos District in central Kenya, TBAs use herbs for initiation of delayed labor and for protracted labor, postpartum hemorrhage, milk initiation, miscarriage, and edema (Kaingu et al. 2011). A 2017 study in Siaya District found that mothers preferred care by TBAs and other nonskilled providers in their communities because TBAs provided herbs to shorten labor that were unavailable in health facilities (Awuor-Mala et al. 2017).

Belief in taboos that connect fertility, health, and wealth requires an ability to think beyond the biomedical model and to recognize what TBAs and other traditional healers have to offer. In coastal Kenya, transgression of taboos is believed to bring illness that traditional healers are able to prevent (Boerma 1990). Research in Siaya District has shown that women's preference for nonskilled providers relates to their ability to reverse taboos and address the spiritual health of mothers through pregnancy, delivery, and the postpartum period (Awuor-Mala et al. 2017).

Traditional birth attendants

TBAs are valued within Kenyan communities. In particular, research among the Samburu by Caulfield et al. (2016) suggests that TBAs strike an effective balance of providing care during pregnancy and birth while also adhering to cultural practices. In many Kenyan contexts TBAs as well as tribe affiliation influence the choices women make around place of delivery, both directly and indirectly. Often, women prefer a birth attendant from the same tribe and are likely to perceive that the chances of finding this connection are greater through a TBA-assisted birth (Warren et al. 2017). Table 1 provides a summary of some of the reasons women have identified preference for delivery care from a TBA.

Table 1 Reasons women prefer delivery care from a TBA

Reason	Source
Poor access to skilled services, better availability of TBAs, no transport or cost required, distance is too far or poor roads	Harun et al. 2012; Mason et al. 2015; Byrne et al. 2016; Caulfield, et al. 2016; Naanyu et al. 2018
Negotiable and cheaper fees or they accept in-kind payments	Mason et al. 2015; Byrne et al. 2016; Naanyu et al. 2018
TBA's sensitivity toward women, nonabusive bedside manner, interpersonal skills, and psychosocial support during labor	Izugbara et al. 2009; Kaingu et al. 2011; Mason et al. 2015
Health facility care is too expensive	Izugbara et al. 2010; Kaingu et al. 2011
Lack of education and awareness of risks of delivering at home	Caulfield et al. 2016; Naanyu et al. 2018
TBAs considered standard for uncomplicated delivery	Izugbara et al. 2010
TBAs naturally and divinely gifted to assist during deliveries	Izugbara et al. 2010
Women tended to use TBAs with their most recent delivery if it was not their first delivery	Wangira et al. 2011
Communities that perceived TBAs as equal to medical professionals tended to go to TBAs	Wangira, et al. 2011
Women feared invasive exams at hospitals	Harun, et al. 2012
Women with low education, advanced age, and high parity tended to use TBAs or unskilled birth attendants	Harun et al. 2012
Women perceive treatment and care at health facilities as disrespectful and unfriendly, preferring TBAs	Caulfield et al. 2016
TBAs respect local and cultural practices and beliefs during pregnancy and delivery	Caulfield et al. 2016
TBAs respect modesty	Caulfield et al. 2016

In pastoralist communities such as among the Samburu, TBAs are particularly highly respected (Caulfield et al. 2016). Research suggests that women perceive TBAs to be more affordable and open to flexible payments, friendlier, and more easily accessible (Mason 2015; Mwangome 2012; Kwambai 2013). Women often describe delivery with a TBA as optimal given the comfortable environment they provide and their willingness to adhere to traditional practices (Rono 2018; Awuor-Mala 2017). Caulfield and colleagues found that among Samburu women TBAs represented a central element in reducing the degree of shame that women felt about being naked in health facilities. Other studies

describe the perceived benefits of TBAs as willingness to allow delivery in squatting or kneeling positions (Awuor-Mala et al. 2017), being less physical and more sensitive, having a nonabusive bedside manner and better interpersonal skills, and ability to provide psychosocial support during labor (Izugbaraet al. 2009; Kaingu et al. 2011; Mason et al. 2015).

Knowledge of safe delivery practices and the role of SBAs is increasing in Kenya. Women are beginning to better recognize that skilled birth attendants have skills that TBAs might not always have. In particular, preference for health facility delivery appears increasingly related to awareness that TBAs potentially lack adequate equipment for a safe delivery (Mason et al. 2015) or have limited knowledge for addressing complications (Byrne et al. 2016; Harun et al. 2013; Izugbara et al. 2010; Mason et al. 2015; Naanyu et al. 2018; Reeve et al. 2016; Wanyua et al. 2014). Within health facilities and among community members, collaboration between TBAs and SBAs is growing, including instances where TBAs encourage women to seek health facility delivery and accompany women to the facility to provide emotional support (Wanyua et al. 2014). Several studies indicate that TBA referrals and maternity education programs are increasing SBA deliveries (Kawakatsu et al. 2014; Naanyu et al. 2018; Tomedi et al. 2015). Further, a study by Karanja and colleagues (2018) reports that increasing health facility delivery hinges on integrating TBAs into the existing health system, assisting midwives to comfort women during labor, and reducing language barriers between women and health care workers.

Regardless of preferences for TBAs or for health facility delivery, many studies show that TBAs have an advantage in offering greater convenience and access. Some studies have found better availability of TBAs and fewer barriers to reaching their care, whereas barriers to health facility delivery include cost for transportation, long distance to the facility, and poor roads (Byrne et al. 2016; Caulfield et al. 2016; Harun et al. 2013; Mason et al. 2015; Naanyu et al. 2018). Several other studies have cited cost and mode of payment as reasons women deliver with TBAs; fees are negotiable and cheaper compared with facility deliveries, and TBAs accept in-kind payments, which were often more affordable for women (Byrne et al. 2016; Mason et al. 2015; Naanyu et al. 2018). Similarly, a few studies have described health facility care as too expensive, leading women to deliver with TBAs (Izugbara and Ngilangwa 2010; Kaingu et al. 2011). Expenses, whether related to the cost of transport or to fees at a health facility, do not necessarily represent singular and insurmountable barriers to health facility delivery. A study in Mswambweni District, for example, reported a fourfold increase in facility deliveries when women had transport provided and the cost of services covered (Mwangome et al. 2012).

Female circumcision

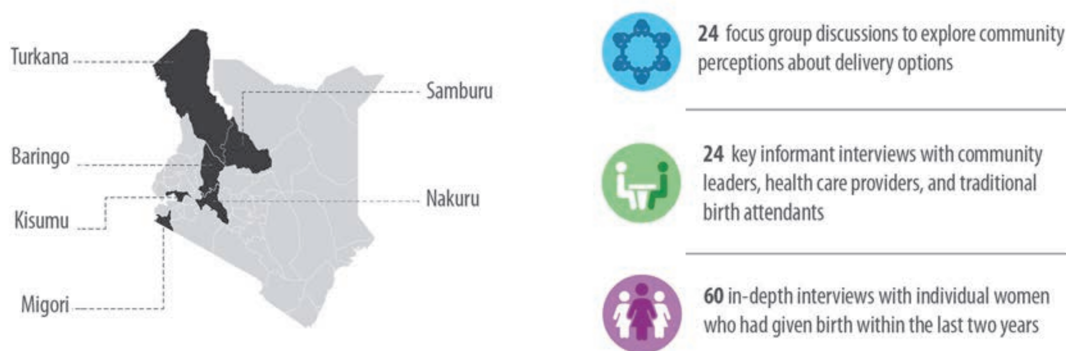
Despite Kenya's legal prohibitions against female circumcision (Mukadi 2017; Ayuko and Chopra 2008), the practice is still present in most Kenyan communities. Among Kenyan women age 15-49, 21% have been circumcised (KNBS 2015; Kimani et al. 2018). For most women circumcision happens before marriage, and in some cases at the time of marriage. Female circumcision represents an important rite of passage that ushers in full participation in household and community activities (Shell-Duncan and Hernlund 2000; Likaka and Muia 2015; Mukadi 2017; Ayuko and Chopra 2008; Mukadi et al. 2015). Among the Rendille in Turkana, enduring the pain of being cut is thought to demonstrate a woman's ability to endure childbirth (Shell-Duncan and Hernlund 2000). In some communities uncircumcised women are not allowed to speak at public gatherings (Mukadi 2017).

Female circumcision increases risks of maternal illness and death during pregnancy, childbirth, and postpartum (Shell-Duncan and Hernlund 2000; Kimani 2014). Women who are infibulated—a common form of circumcision throughout Kenya—cannot give birth unassisted and are at increased risk for complications (Shell-Duncan and Hernlund 2000). Because infibulation includes the surgical removal

of the external female genitalia and the suturing of the vulva, defibulation (the reversal of infibulation) is necessary for vaginal birth, and can result in increased tearing and bleeding, potentially requiring hospital management (Shell-Duncan and Hernlund 2000). Circumcision is typically performed by TBAs or other traditional practitioners in communities. In recent years, some medicalization has been reported, most often after delivery or other gynecological procedures (Kimani et al. 2018). However, postdelivery (re)circumcision requested by women delivering in health facilities presents a legal and ethical dilemma for providers (Shell-Duncan and Hernlund 2000).

Shifting norms around female circumcision in Kenya present complexities for women in determining where to deliver. Studies have found that some circumcised women prefer to deliver at home with assistance from the TBAs who performed their circumcision; some may avoid delivering in facilities that prohibit medical circumcision (Shell-Duncan and Hernlund 2000; Rono et al. 2018); and others may avoid delivering in any facility due to fear of stigma, disrespect, and abuse (Rono et al. 2018). Women who choose not to be circumcised face pressure to conform to tradition, particularly in the context of childbirth. There is an emerging trend among married women to be circumcised after giving birth to their first child or before becoming pregnant with a second child, instead of before marriage. Omondi (2017) has suggested that this trend is the result of pressure from family members and others in the community with ties to the family. Research within pastoralist communities suggests that fear of stigma potentially perpetuates two options: specifically, uncircumcised women choosing to deliver at a health facility and circumcised women choosing to deliver unassisted or alone (Caulfield et al. 2016).

2 DESIGN, METHODS, AND IMPLEMENTATION



ICF designed and led this study, and worked in collaboration with the Nairobi-based research firm Health Strat to undertake the study. The study investigated beliefs and experiences relating to place of delivery in six counties (Baringo, Kisumu, Migori, Nakuru, Samburu, and Turkana). To guide the study, ICF and Health Strat established three interrelated research questions:

1. How do pregnant women make and implement choices about where to deliver?

2. Why do pregnant women choose not to deliver at health facilities, even when such facilities appear to be available?

3. What individual factors and contextual factors beyond individual agency influence women's behavior with regard to where they deliver?

The study team included a senior advisor, two senior researchers, and three research assistants from ICF; and one senior researcher, one senior maternal and child health expert, and 12 interviewers from Health Strat. The ICF Internal Review Board (IRB) and the AMREF Health Africa Ethics Scientific Review Committee reviewed and approved the study protocol. Data collection included 24 focus group discussions, 24 key informant interviews, and 60 in-depth interviews. ICF and Health Strat worked collaboratively in managing data collection, the transcription of interviews and focus group discussions, and data coding and analysis, which was undertaken using NVivo 12.

2.1 Data Collection Methods and Tools

Qualitative research methods and procedures guided the design and implementation of the study. Methodologically, data collection included focus group discussions, key informant interviews, and in-depth interviews. In using three types of interviews, the aim was to explore the research questions in a group context, including focusing on areas of agreement and disagreement, while also capturing the perspectives of both individual women and community members in relation to pregnancy, delivery, and maternal health. Applied research of this type benefits from including multiple interview types to facilitate in-depth exploration and data triangulation (Mack et al. 2011; Tolley et al. 2016).

A guide for each of the three interview types was prepared in English. Each of the three guides included questions in relation to four specific topics: 1) health services in general, 2) pregnancy, 3) delivery, and 4) social and family support. The intent in organizing the guides around these four topics was to ensure investigation of not only delivery experiences but also the broader contextual factors and tensions across the pregnancy-to-birth continuum.

Similar to the methodological approach known as patient journey mapping (McCarthy et al. 2016; Meyer 2018), the data collection tools were designed with the aim of mapping the journey for Kenyan women from the time when they learn they are pregnant to when and where they give birth. A journey mapping approach recognizes that the path for a patient from the starting point to the ending point often is not a straight line. With any such journey, many economic, familial, and sociocultural factors must be navigated along the way; thus the data collection tools were designed to elicit the details and nuances of a woman's journey from the initial awareness of pregnancy to delivery of the birth. In addition to the focus on mapping journeys, the data collection tools were designed bearing in mind narrative research methods (McAlpine 2016; Wang and Geale 2015). Part of mapping a patient journey includes uncovering a story or the narrative and context related to a woman's delivery experience.

The focus group discussion guide included 16 open-ended questions, with possible probes listed for each question. The key informant and in-depth interview guides were semi-structured and included 20 open-ended questions, with possible probes listed for each question, and a series of closed-ended questions. There were two types of closed-ended questions:

1) 22 questions in the in-depth interview guide to gather general demographic and socioeconomic information about the participant

2) 33 yes-no questions in both the key informant and in-depth interview guides to gain a broad sense of perceptions, beliefs, and experiences in relation to the four topics (health services in general, pregnancy, delivery, and social and family support)

Both types of closed-ended questions helped the interviewer to be introduced to the participant, build rapport, and ease into the interview. The wordings of the 33 yes–no questions were adjusted slightly to account for the different vantage points of a key informant interview participant and an in-depth interview participant. Including the same 33 yes–no questions in the key informant and in-depth interviews also provided an avenue to consider that what community leaders, health care providers, and traditional birth attendants think is the perception, belief, or experience of members of their community might not always align with what community members themselves indicate as their perception, belief, or experience.

Given the linguistic diversity across the data collection sites, each of the three interview guides was translated into Luo, Kalenjin, Samburu, Swahili, and Turkana. Native speakers undertook the translations, and to the extent the schedule and budget allowed, multiple native speakers contributed to each translation. As part of their training, interviewers undertook back translations. Overall, the approach to translation strived for balance between establishing a precise and agreed-upon translation for each question in the guides, and also recognizing that interviewers were specifically trained to use the questions as guides to interviewing rather than as scripts to read verbatim. The three English guides are presented in Appendix 1.

2.2 Site Selection

The starting point for site selection was the 10 USAID/Kenya MCH high-priority counties, rather than all 47 counties in Kenya. In light of this requirement, the site selection and the study overall are aligned to a specific and targeted data collection and analysis request pertaining to the set of counties that USAID/Kenya has categorized as high-priority MCH counties. It was not feasible to collect data in all 10 USAID/Kenya MCH high-priority counties given the timeline and budget; therefore, selecting six counties was a purposeful exercise. The six counties selected—Baringo, Kisumu, Migori, Nakuru, Samburu, and Turkana—vary in population size and population density, and in relation to numerous climatic, cultural, economic, ethnic, geographical, historical, linguistic, livelihood, and social factors. Their selection was informed by the following factors:

- Including Baringo, Nakuru, Samburu and Turkana Counties, given ongoing USAID-funded maternal health projects
- Including Kisumu and Migori Counties, given their more Western geographic location in comparison with inclusion of Kilifi and Kitui counties
- Including Kisumu and Migori Counties, to accommodate a limited budget and timeline for translations compared with inclusion of Kakamega, Kilifi, and Kitui Counties

For each of the six counties, ICF and Health Strat team members collaboratively selected sub-counties and wards. This selection process took place before the data collection teams travelled to the six counties. The guiding element for site selection was to strive for balance in relation to the number of and distance to health facilities as delineated in the Kenya Master Health Facility List (KMHFL).[1] Each sub-county and each ward within the sub-county were selected based on the density of health facilities—with high density generally found in peri-urban wards and low density generally found in rural wards. In each county, one peri-urban and one rural ward were selected.

The map in Figure 2 shows the approximate location of the 12 selected wards.

Health Strat took the lead in requesting permission for data collection from the County Directors of Health (CDH) and County Reproductive Health Coordinators (CRHC) for each of the six counties. Each of the six data collection teams met with their respective CDHs to request the signed authorization letter; in turn, the signed letters facilitated entry into the sub-counties and wards. The data collection teams explained the site selection strategy, and the CDHs were given an opportunity to suggest adjustments, which were honored to the extent possible.

Table 2 provides an overview of the interview types for each data collection site.

[1] The Kenya Master Health Facility List (KMHFL) is publicly available: http://kmhfl.health.go.ke/#/home.

Figure 2 Location of selected wards for data collection

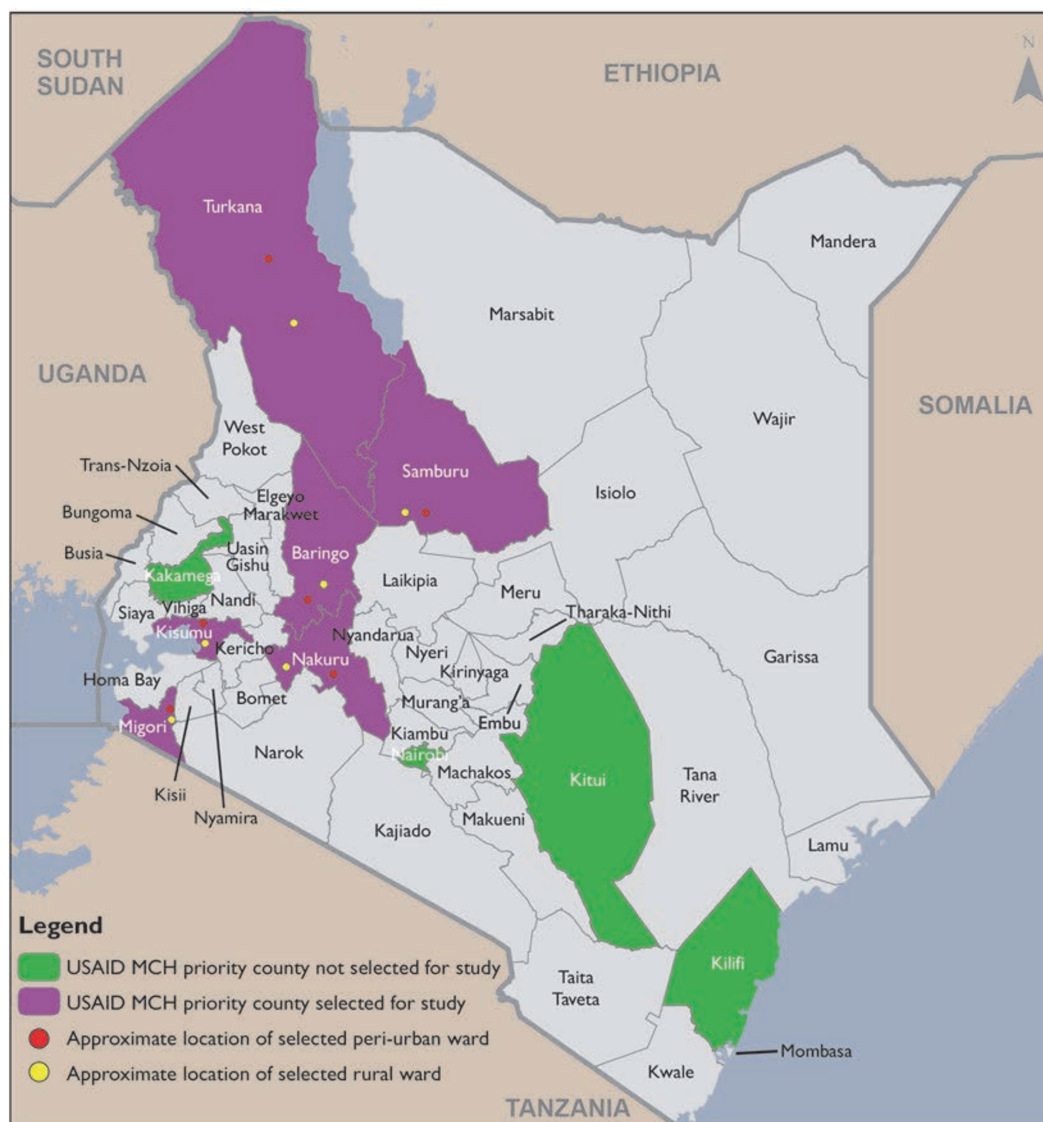


Table 2 Data collection sites and types of data collection

County	Sub-County	Ward	Focus Group Discussion	Key Informant Interview	In-Depth Interview	TOTAL
Baringo	Koibatek	El Dama Ravine	2	2	5	9
Baringo	Koibatek	Lembus Perkerra	2	2	5	9
Kisumu	Kisumu West	North West Kisumu	2	2	5	9
Kisumu	Kisumu West	Kisumu West	2	2	5	9
Migori	Rongo	Central Kamagambo	2	2	5	9
Migori	Rongo	South Kamagambo*	2	2	5	9
Nakuru	Gilgil	Eburu Mbaruk*	2	2	5	9
Nakuru	South Kuresoi*	Kiringet*	2	2	5	9
Samburu	Samburu Central	Maralal	2	2	5	9
Samburu	Samburu Central	Loosuk	2	2	5	9
Turkana	Loima	Turkwel	2	2	5	9
Turkana	Loima	Lopei-Kotaruk	2	2	5	9
SIX COUNTY TOTALS			**24**	**24**	**60**	**108**

**Adjustment to site selection per the suggestion of CDH.*

2.3 Participant Recruitment

The six data collection teams consisted of two interviewers per team. Upon arrival in their respective counties, each pair of interviewers coordinated with the county and sub-county CDH, CRHC, and other county and government health officials, including public health and community outreach officers. Through these consultations, each of the six data collection teams identified a community health volunteer (CHV) to assist in selecting communities within the ward and specific study participants.

The 24 focus group discussions, 24 key informant interviews, and 60 in-depth interviews yielded a total of 303 study participants. Among the 303 study participants, 73 were male and 230 were female. Table 3 provides an overview of the recruitment criteria and the study participants per interview type.

Table 3 Recruitment criteria and study participants for each interview type

Interview Type	Number of Participants		Recruitment Criteria	TOTAL
	Male	Female		
Focus Group Discussion	73	146	▪ Women who have given birth in last two years ▪ Men of reproductive age with a child under five ▪ 6 to 12 participants per focus group discussion ▪ All men and women at least 18 years old	219
Key Informant Interview	0	24	▪ Community leaders (6) ▪ Facility-based health care providers (9) ▪ Traditional birth attendants (9) ▪ At least 18 years old	24
In-Depth Interview	0	60	▪ Women who have given birth in last two years ▪ Balance of home and health facility delivery ▪ At least 18 years old	60
TOTAL	**73**	**230**		**303**

2.4 Training, Translations, and Data Collection

Health Stat employed 12 interviewers for data collection. There were two interviewers for each county, with the designation made in relation to familiarity with the county, including linguistic familiarity. Training took place in Nairobi from April 9–16, 2018 and was led by two senior researchers from ICF and one senior researcher and one maternal and child health expert from Health Strat. Training for data collection focused on the ethics and process associated with interviewing, the subject matter of the interview guides, the nuances of translating from English to local languages, and specific techniques for interviewing. Training for transcription focused on ensuring a full understanding of what a verbatim transcript entails.

A one-day pilot was held with the assistance of staff from the Mai Mahiu Health Centre in Nakuru County. The interviewers were divided into small groups to conduct in-depth interviews, key informant interviews, and focus group discussions, with oversight from ICF and Heath Strat. Upon returning to Nairobi, the team shared feedback from the pilot exercise and adjusted the interview guides accordingly. The specific changes made concerned refining the translations from English to local languages.

Data collection took place from April 17 to May 7, 2018. The interviewers obtained written informed consent to conduct and record all 108 focus group discussions and interviews. All study participants were given the opportunity to speak in the language they were most comfortable with. Interviews and focus group discussions took place in locations where the participants felt most comfortable. Each interview lasted approximately one hour and each focus group discussion approximately two hours.

2.5 Transcription, Data Coding, and Analysis

The interviewers transcribed each audio-recording from the specific language into written English. Transcription began April 23 and was completed by May 29, 2018. All 108 transcripts—the data—were coded in NVivo 12 software. Data coding topically categorizes and organizes the content of transcripts and represents the first step in identifying themes across the data. To code the data, team members from ICF and Health Strat developed a set of thematic codes based on the organization of the interview guides and a review of the initial transcripts. The codebook is provided in Appendix 2.

Team members from ICF and Health Strat coded the 108 transcripts from May 21 to June 4, 2018. The timeline and budget did not allow for double coding or the addition of new codes once coding was underway. To facilitate consistency in applying codes and to be iteratively thinking about and analyzing the data, the team regularly communicated during the coding process.

After coding was complete, an analysis workshop was held in Nairobi from June 18–22, 2018, during which the team ran queries on the coded data to analyze the content and themes that emerged from the data. During and following the analysis workshop, the team worked collaboratively to organize themes and content for the report.

2.6 Challenges and Limitations

High-quality qualitative research requires neutrality as well as a commitment to refrain from advocating or casting judgment. In particular, for a study on place of delivery, the interview questions and conducting interviews cannot become a forum for advocating to the study participants the benefits of health facility delivery. **Maintaining neutrality is a goal not without challenges** while designing the study and collecting data.

Qualitative research methods signal a specific type of study design, and this study, like other qualitative studies, may entail common limitations such as the **limited generalizability of the data** and potential bias in responses by the participants. In addition, data quality may depend on the skill of the data collection teams.

Each of **the selected counties is socially and culturally diverse.** To capture more of the variation that exists within the selected counties, the study collected data in a peri-urban and rural ward; however, these represent just two of the numerous wards in each county and represent just one of the possible sources of variation in a county.

In some instances county-level staff and CHVs appeared **reluctant to acknowledge home deliveries** that occur in the selected wards, seemingly for fear of negative sanctions. This caused delays during data collection and required teams to crosscheck information received before finalizing participant recruitment. The teams attempted to identify and include participants with a range of delivery experiences. Nonetheless, the reluctance to acknowledge home deliveries may have biased the participant recruitment toward women with experience with or a preference for delivery in a health facility.

The **terrain and geographic distribution** of some of the selected wards posed challenges. In particular, gathering participants who live far apart for focus group discussions required considerable time. Across the six counties, heavy rains during data collection disrupted numerous interviews.

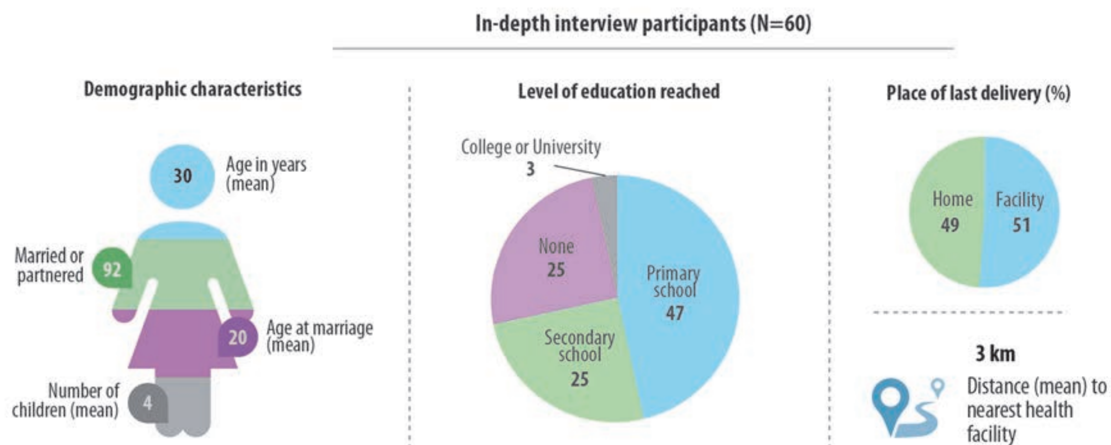
Some participants were reluctant to answer questions. In particular, during focus group discussions, the **expectation for monetary compensation** resulted in participant apprehension. When participants were reluctant, the interviewers provided assurances that the views of everyone in the group were important. The interviewers offered encouragement but, ultimately, an interviewer cannot and should not try to force a focus group discussion participant or any participant to answer questions.

Interviews and focus group discussions were **conducted in six different languages**, audio-recorded, and translated directly from the audio recording into English. Completing a transcript required a strong command of both the local language and English in order to capture linguistic complexities and nuances. Cases in which the interviewer's command of English was limited resulted in poorer-quality transcripts.

All participants in the study were at least age 18. As such, the study does not include examination of experiences of women under age 18, which may differ from those of older women. Further, the study's focus was primarily women, resulting in **limited inclusion of men's perspectives**. For each of the 12 wards, the data collection teams attempted to conduct one focus group discussion with women and one focus group discussion with men; in Kisumu and Migori Counties, however, the teams were unable to conduct focus group discussions with men only.

The dataset consisting of 108 interview and focus group discussion transcripts across the six counties represents a vast amount of data. Although this study attempts to be comprehensive, it is impossible to be exhaustive in presenting results. **The report presents only a small amount of the data collected.**

3 CHARACTERISTICS OF THE PARTICIPANTS



Among the 303 study participants, the 6 data collection teams reached 219 participants through focus group discussions, 24 through key informant interviews, and 60 through in-depth interviews. Focus group discussions included 146 female participants and 73 male participants. Key informant interview participants were all female, including 6 community leaders, 9 facility-based health care workers, and 9 traditional birth attendants. In-depth interview participants were all women who had given birth in the last two years. Collectively, across the 303 study participants, 230 were female and 73 were male.

Chapter 3 presents initial and introductory findings, focusing on the demographic and socioeconomic characteristics across the 60 in-depth interview participants. The tables present the data for all participants, followed by the data broken into peri-urban ward participants and rural ward participants.

Appendices 3, 4, and 5 present responses to the yes–no questions posed to key informant interview participants and the demographic and yes–no questions posed to in-depth interview participants.

3.1 Characteristics of the In-Depth Interview Participants

All 60 in-depth interviews were conducted with women age 19-45 (mean age 30.0). On average, the participants in the rural wards were slightly younger than those in the peri-urban wards. Nearly all participants (92%) reported being married. The mean age at first marriage among those who were ever married was 19.6 (range age 12-29). Table 4 provides a summary of the age and marital status of the in-depth interview participants.

Nearly half (45%) of the women interviewed reported farming as their primary occupation, while about a fifth (22%) reported being housewives. Other occupations included business, retail, or vending (21%) and casual work/labor (5%). Table 5 provides a summary of the occupation of the in-depth interview participants and their partners.

Table 4 Age and marital status of in-depth interview participants

Characteristic	All Participants		Peri-Urban Ward Participants		Rural Ward Participants	
	Response	N	Response	N	Response	N
Women's age in years (mean)	30.0	60	30.2	30	29.4	30
Women's age at marriage in years (mean)	19.6	57	19.4	29	19.9	28
Women's marital status (%) (N = 60)						
Married or partnered	91.7	55	90.0	27	93.3	28
Single	3.3	2	3.3	1	3.3	1
Widow	1.7	1	3.3	1	0.0	0
Divorced	1.7	1	0.0	0	3.3	1
Other	1.7	1	3.3	1	0.3	0

Table 5 Occupation of in-depth interview participants and their partners

Characteristic	All Participants		Peri-Urban Participants		Rural Participants	
	Percent	N	Percent	N	Percent	N
Women's primary occupation (N = 58)						
Farmer	44.8	26	41.4	12	48.3	14
Business, retail, vending	20.7	12	31.0	9	10.3	3
Casual work, laborer	5.2	3	0.0	0	10.3	3
Housewife	22.4	13	20.7	6	24.1	7
Other	6.9	3	6.9	2	6.9	2
Husband's or partner's primary occupation (N = 53)						
Farmer	37.7	20	30.8	8	44.4	12
Business, retail, vending	15.1	8	23.1	6	7.4	2
Casual work, laborer	5.7	3	0.0	0	11.1	3
Mechanic, electrician, mason, miner	11.3	6	11.5	3	11.1	3
Health service, health facility, pharmacy	7.6	4	0.0	0	14.8	4
Other	22.6	12	34.6	9	11.1	3

Except for one participant, all women reported Christianity as their religion (See Appendix 3.1).

Tribe varied by geographical location. There were 10 in-depth interview participants in each of the six counties. In Baringo County five of the ten participants were Kalenjin, four were Kikuyu, and one was Kamba. Among participants from Kisumu and Migori Counties, nine of ten in each country were Luo. In Nakuru County five participants were Kalenjin, one was Kikuyu, one was Kisii, one was Turkana, one was Maasai, and one was Luo. In Samburu County nine participants were from the Samburu tribe. In Turkana County, all ten participants were from the Turkana tribe. (See Appendix 3.2.)

While 25% of the in-depth interview participants had no formal schooling, approximately half (47%) reported reaching primary school and a quarter (25%) secondary school, while only two women (3%) had a college or university level education.

The mean household size was 6.9 individuals (range 3 to 15). Participants reported having lived in their households for an average of 7.4 years. Most of the households were headed by the participants' husbands (82%), while five women said they were the household head. Table 6 provides an overview of the education and household characteristics of the in-depth interview participants.

Table 6 Level of education and household characteristics of in-depth interview participants

Characteristic	All Participants		Peri-Urban Participants		Rural Participants	
	Response	N	Response	N	Response	N
Women's level of education reached (%) (N = 60)						
None	25.0	15	23.3	7	26.7	8
Primary school	46.7	28	50.0	15	43.3	13
Secondary school	25.0	15	23.3	7	26.7	8
College or university	3.3	2	3.3	1	3.3	1
Head of household in relation to participant (%) (N = 60)						
Father	1.7	1	3.3	1	0.0	0
Husband	81.7	49	83.3	25	80.0	24
Wife	1.7	1	3.3	1	0.0	0
Father-in-law	5.0	3	3.3	1	6.7	2
Participant is head of household	8.3	5	6.7	2	10.0	3
Other	1.7	1	0.0	0	3.3	1
Number of family members living in house (mean)	6.9	60	7.4	30	6.4	30
Time lived in house in years (mean)	7.4	59	8.3	30	6.5	29

The mean number of pregnancies reported by the participants was 4.4 (range 1–11 pregnancies). The mean number of living children was 4.2 (range 1–10 children). Five women reported being pregnant at the time of the interview.

Reported distance to the nearest health facility ranged from 300 meters to 10 kilometers (mean distance 3.0 kilometers). Women from peri-urban wards reported shorter distances to a health facility (mean distance 2.6 km) than women from rural wards (mean distance 3.4 km). The frequency of ANC visits during the most recent pregnancy ranged from none to eight, with 35 women (58%) reporting four or more visits and six women (10%) reporting not attending ANC.

Concerning the place where their most recent birth was delivered, 29 women (54%) reported delivering at home, 20 (37%) in a public health facility, 2 (6%) in a private health facility, and 2 (4%) in a mission hospital. Home deliveries were more frequent among women in rural wards than in peri-urban wards (52% and 47% respectively). Place of delivery also varied by level of education. Among women with no formal education, 12 (80%) delivered at home, while 16 women with primary school education (64%) and 1 woman with secondary education (8%) delivered at home. None of the women with college or university education reported having their most recent birth delivered at home (See Appendix 3.3).

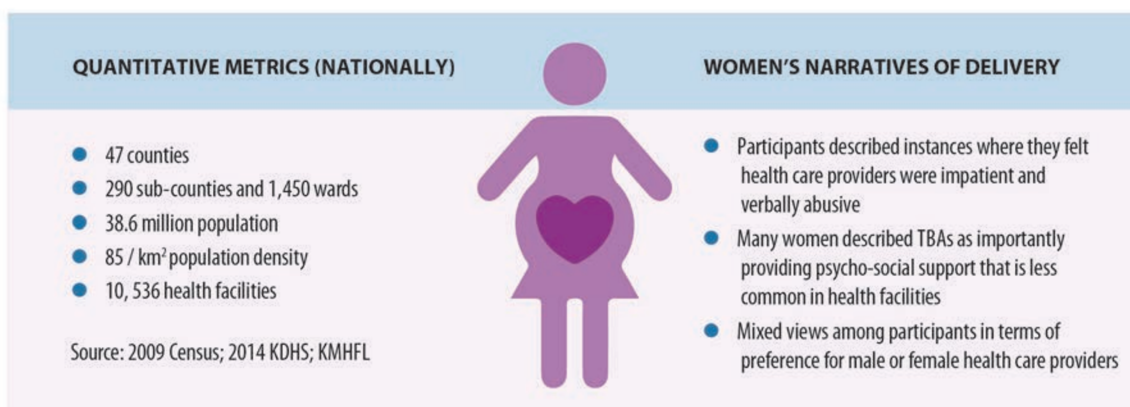
There appeared to be no single period in the course of pregnancy when most women were thinking about where they would deliver. Responses to this question were distributed relatively evenly, with 8 women (15%) saying they thought most about where to deliver during the first trimester, 15 (28%)

during the second trimester, and 12 (22%) during the third trimester. Fourteen women (during the first trimester 26%) reported thinking about where to deliver throughout their most recent pregnancy, while five (9%) stated that they did not think about place of delivery at all during the pregnancy. Table 7 provides a summary of the previous pregnancies and deliveries of in-depth interview participants.

Table 7 Previous pregnancies and deliveries of in-depth interview participants

Characteristic	All Participants		Peri-Urban Participants		Rural Participants	
	Response	N	Response	N	Response	N
Number of times pregnant (mean)	4.4	60	4.9	30	3.9	30
Number of living children (mean)	4.2	60	4.6	30	3.7	30
ANC visits with last pregnancy (%) (N = 60)						
0 Visits	10.0	6	13.3	4	6.7	2
1 Visit	10.0	6	3.3	1	16.7	5
2 Visits	10.0	6	10.0	3	10.0	3
3 Visits	11.7	7	13.3	4	10.0	3
4 Visits	43.3	20	53.3	16	33.3	10
4 + Visits	15.0	15	6.7	2	23.3	7
Place of last delivery (%) (N = 59)						
Home	49.2	29	46.7	14	51.7	15
Public Hospital	40.7	24	43.3	13	37.9	11
Private Hospital	5.1	3	6.7	2	3.5	1
Missionary Hospital	5.1	3	3.3	1	6.9	2
During your last pregnancy at what point were you thinking most about place of delivery? (%) (N = 54)						
Months 1-3	14.8	8	14.8	4	14.8	4
Months 4-6	27.8	15	29.6	8	25.9	7
Months 7-9	22.2	12	14.8	4	29.6	8
All 9 Months	25.9	14	29.6	8	22.2	6
Did not think about it	9.3	5	11.1	3	7.4	2

4 NARRATIVES OF DELIVERY AND CONTEXTUAL STARTING POINTS



This chapter begins with a county-by-county lens and presents both county-level quantitative metrics and women's narratives of delivery. The approach in this chapter applies elements of journey mapping (McCarthy et al. 2016; Meyer 2018) and narrative research methodology (McAlpine 2016, Wang and Gaele 2015). By focusing attention on the experiences of individuals, the goal with this chapter is to consider women's narratives of delivery and to look for the stories and insights that emanate from the details shared by the female study participants. Understanding the stories and the embedded perceptions, tensions, and experiences aims to be a pathway for discussion and to refine and enhance policies and programming strategies focused on maternal and child health.

Presenting some of the data from the qualitative study at the county level offers a valuable focused look; however, it is important to recognize that these county-level data cannot be thought of as representative of the county. As Table 8 reminds, each county-level dataset is smaller than the collective six-county dataset.

Table 8 Study participants by county

	Female Focus Group Discussion Participants	Female In-Depth Interview Participants	Male-Only Focus Group Discussion Participants
Baringo	27	10	18
Kisumu	38	10	0
Migori	34	10	0
Nakuru	29	10	19
Samburu	20	10	18
Turkana	18	10	14

The second half of the chapter moves away from a county-by-county presentation to consider the dataset collectively. To highlight the context in which women experience the pregnancy-to-delivery continuum, the analysis focuses first on findings from the male-only focus group discussions. Table 8 includes the breakdown of participants for the male-only focus group discussions, which were conducted in four of the six counties. The chapter concludes by presenting findings across the full dataset of focus group discussions, key informant interviews, and in-depth interviews in relation to geographic challenges.

4.1 Baringo County

Census 2009 / KMHFL

- 6 sub-counties in the county
- 29 wards in the county
- 555,561 population
- 11,015 km^2 area
- 50 / km^2 population density
- 209 health facilities in the county

2014 KDHS

- 86% literate
- 20.7 median age at first marriage
- 6.2 mean number of children ever born
- 93% received ANC from skilled provider
- 54% health facility delivery
- 45% home delivery

Place of Delivery Qualitative Study – Women's Narrative of Delivery Quotes from Baringo County

The population density in Baringo County is relatively low. The county-level rate of health facility delivery is slightly below the national average of 61%. The women's narratives of delivery presented below highlight geographical and transportation challenges facing women as well as other nuances such as:

- When labor begins at night, the chances of delivering at home or on the road likely increase.
- Between their mother, mother-in-law, and extended family, it is likely most women know a TBA.
- While motorbikes resolve some transportation problems, lack of ambulances remains a problem.

My labor pains take one hour. You might be in labor at night and maybe you are just with the mother-in-law and she is afraid, she cannot walk, and the hospital is far so you are supposed to deliver at the home of your mother-in-law. You move and already the water has broken so there is no way you can prevent it, so you just have to deliver at home.

You know at home they use a razor, stem of a sugar cane, and thread. I delivered at the roadside and they used a sugar cane that had not been chewed and they used it to cut the umbilical cord and they tied it with a thread. The hospital is better. I bled. I bled so much.

When I think about it because that time I had not known. You know I got married and I was put in reserve (rural) and my mother is a TBA, so I knew whatever she says you are supposed to do. We were still going to the hospital and the hospital was far. When we did not have far and we were on foot, it [labor and delivery] happened abruptly. But the baby is normal.

Female Focus Group Discussion Participant
Ravine Ward

At this rainy season, women go far and can deliver by roadside, which is not good. If she delivers by roadside it will still be expensive to her, she goes to be examined at Ravine. Say someone goes to Sagat and on reaching there it is closed and on coming back she delivers along the way. Who would assist and there is no one to help?

Like recently, there was a pregnant woman, she had done a lot of work and felt waistline pains. Because of far distance to the hospital her water broke in a motorbike and the baby still survived.

Dirt got to the rider and the road is not passable, vehicles cannot go through it, so it was a challenge. Maybe she could have gone to Sagat and been attended fast. Maybe her water could have not broken by the road.

Challenges are many, like there are no ambulances. If vehicles could be present at Sagat and a problem arises and the ambulance is called or a woman almost delivers by roadside the vehicle is called for very fast she gets help it could be very okay.

Female Focus Group Discussion Participant
Lembus Perkerra Ward

4.2 Kisumu County

Census 2009 / KMHFL

- 7 sub-counties in the county
- 34 wards in the county
- 968,879 population
- 2,086 km^2 area
- 460 / km^2 population density
- 226 health facilities in the county

2014 KDHS

- 93% literate
- 19.1 median age at first marriage
- 5.6 mean number of children ever born
- 98% received ANC from skilled provider
- 70% health facility delivery
- 29% home delivery

Place of Delivery Qualitative Study – Women's Narrative of Delivery Quotes from Kisumu County

The population density in Kisumu County is relatively high. The county-level rate of health facility delivery is slightly above the national average of 61%. The women's narratives of delivery quoted below include examples of negative experiences in maternity wards as well as other nuances such as:

- Sometimes TBAs and facility-based service providers give different assessments and information.
- A common perception among women is that respectful maternity care is lacking at facilities.
- Often, maternity wards have a limited number of beds for women in labor or ready to deliver.

My first time going to the clinic was a day after I went to the TBA and she told me to go to the clinic. The nurse who gave me a card after paying 50 shillings [approximately US$ 0.50]. After giving me the card she told me to climb on the bed so she can do a check-up on me. After the check-up the nurse told me I was carrying twins and the twins are in a wrong position.

I was stressed and started thinking why would the TBA not tell me that the child is in a bad position. I was stressed that I could not handle so I left the hospital and went to the TBA but I did not find her. I went the following day at 6.00 a.m. and told her: "You told me to go to the clinic and they told me that I am carrying twins and they are not positioned well. That means there is nothing you did." She checked me again and told me that I am carrying one baby and the baby is positioned well. She told me what the nurse said is not right and that is why we always go to the TBA.

When we go to deliver at the TBA she is kind and pampers us but in the hospital the person who should be helping you is busy scrolling the phone on Facebook. While I am in labor and when she hears me screaming and shouting in pain she says she is not the one who sent me to conceive.

Female Focus Group Discussion Participant
North West Kisumu Ward

When you get there, they tell you to climb the bed so you can be tested to see how many centimeters away from delivery is the baby. When that time elapses, you are again taken for testing. If they see it has taken long you will be injected to bring the baby because if the baby overstays it is also not good as it drinks the bad water.

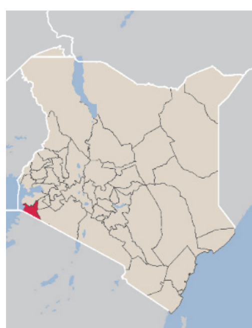
When injected you deliver quickly. Like for me, I slept there two days as I went during the day, spent the night and gave birth the following day in the morning. I have never slept at the hospital before. Normally I go and deliver in hospital the same day, they had to inject me to deliver.

In-Depth Interview Participant
Kisumu West Ward

I had a prolonged labor that lasted for eight hours. I went to deliver in the hospital. I found the ward was full and there was no free space for any women to deliver. After delivery, I was discharged immediately because there were no beds for us to sleep in.

In-Depth Interview Participant
Kisumu West Ward

4.3 Migori County



Census 2009 / KMHFL

- 8 sub-counties in the county
- 39 wards in the county
- 917,170 population
- 2,586 km^2 area
- 355 / km^2 population density
- 223 health facilities in the county

2014 KDHS

- 86% literate
- 17.1 median age at first marriage
- 7.0 mean number of children ever born
- 96% receive ANC from skilled provider
- 53% health facility delivery
- 44% home delivery

Place of Delivery Qualitative Study – Women's Narrative of Delivery Quotes from Migori County

The population density in Migori County is relatively high. The county-level rate of health facility delivery is below the national average of 61%. The women's narratives of delivery quoted below exemplify some of the types of fears that women feel as well as other nuances such as:

- Women tend to be aware that a clean space and sanitized instruments are optimal for delivery.
- Feeling afraid can relate to either facility delivery with an SBA or home delivery with a TBA.
- HIV testing is potentially a barrier for facility delivery and also a motivator for facility delivery.

Yes, there are some TBAs who are not clean. You find the house is dirty. Like it was mentioned, some TBAs make women deliver on sacks on the floor.

The baby can get infected with some diseases because the baby may have fallen down and the head touches the floor and is infected.

Now you will be scared to deliver in that dirty place. You must have fear. Depends on how the TBA has taken care of her house.

Female Focus Group Discussion Participant
Central Kamagambo Ward

If I am HIV-positive and I do not want the doctor to know I will decide to go and deliver at the TBA because I will not be tested.

In the hospital, it is a must to be tested for HIV.

Like for me if I fear to be tested I will go and deliver at the TBA, she will help me deliver, after delivering she cuts the umbilical cord then I go back home.

Female Focus Group Discussion Participant
South Kamagambo Ward

Maybe you have gone to the delivery room [at a health facility] and you see those scissors even before they are used on you. You become scared. You look at them and wonder:

They will use all these to cut me?
This is what they use to stitch people up?
I cannot come back here.

That will scare you and you end up going away.

Sometimes you find someone had delivered and the area is still dirty. Those baby's things are still there. You say: I cannot come back here.

Female Focus Group Discussion Participant
Central Kamagambo Ward

My pregnancy with this other child I had a problem. I delivered this child and finished three months still having my monthly periods then it disappeared completely until I got pregnant with this other child. They did for me, how do you call it, scanning.

It is good. If I was at home I would have been worried until the end. I went there and knew my status and that helped me, at least it reduced the fear a bit. It is good to go to the hospital to know your status when pregnant.

Female Focus Group Discussion Participant
South Kamagambo Ward

4.4 Nakuru County

Census 2009 / KMHFL

- 11 sub-counties in the county
- 55 wards in the county
- 1,603,325 population
- 7,510 km^2 area
- 213 / km^2 population density
- 451 health facilities in the county

2014 KDHS

- 94% literate
- 20.6 median age at first marriage
- 4.7 mean number of children ever born
- 96% received ANC from skilled provider
- 70% health facility delivery
- 30% home delivery

Place of Delivery Qualitative Study – Women's Narrative of Delivery Quotes from Nakuru County

The population density in Nakuru County is relatively high. The county-level rate of health facility delivery is above the national average of 61%. The women's narratives of delivery quoted below provide a sense of how women overcome pregnancy and delivery challenges and other nuances such as:

- An unplanned or unwanted pregnancy potentially creates an additional set of challenges.
- Moving through pregnancy and delivery often requires women to exhibit fortitude and resilience.
- In working to overcome challenges, what women do is sometimes viewed as the expected norm.

I decided because I have this pregnancy, I will not eat. I would wake up in the morning, drink tea and go to the farm. I would not use the road so someone would not see me because of contempt for myself. I would walk by the boundaries of the farms and go dig and come back at 1 p.m. and give the children food. I would not eat. I would go back to the farm. Because I felt if I ate, people would see that I am pregnant.

I felt I had a problem when I started to bleed. But, I did not see it as a problem because I was just at home. As I said before, I had gone to the hospital felt no, I cannot be attended to by those [young] girls. I came back home and I stayed. That night when I felt sickly, I decided to call a woman who had delivered recently. She came and we spent the night here together.

In the morning, I saw I had not been assisted. I called another woman. She bathed me. I told her I was not feeling anything. I told her to look for a doctor to come and attend to me.

The doctor came and found I had delivered. Before the doctor came, I fainted. The doctor gave me an injection and I stopped bleeding. I regained consciousness. The doctor told me to sit and if I feel unwell to call him.

In-Depth Interview Participant
Eburu Mbaruk Ward

PAR: When I feel the baby is coming, I put more strength in pushing so I push until it comes out. I put the mattress on the floor. I deliver on top of the mattress. The baby comes out and I look for a napkin. I take the razor. I tie the cord. I tie a string and cut with a razor. I wrap the baby in the napkin then I do this [illustrates by massaging her stomach]. Then that thing comes out.

INT: The placenta?

PAR: The placenta it comes out fast. I wrap it. I sit well. I take porridge.

INT: Oh, so you prepare before?

PAR: Yes, before. When I feel the baby I take porridge and get strength to push. I push until it comes out. Then I put the baby to sleep. Then I remove the placenta.

INT: What do you do with the placenta?

PAR: I take it to the toilet. At that moment, I do not have strength. I wrap it with rags. Then when I can stand, I take the porridge then my body feels fine. There is no baby I gave birth to during the day just one girl. All the other children I deliver at night

In-Depth Interview Participant
Keringet Ward

4.5 Samburu County

Census 2009/KMHFL

- 3 sub-counties in the county
- 15 wards in the county
- 223,947 population
- 20,182 km^2 area
- 11 / km^2 population density
- 72 health facilities in the county

2014 KDHS

- 40% literate
- 18.4 median age at first marriage
- 6.5 mean number of children ever born
- 74% received ANC from skilled provider
- 25% health facility delivery
- 74% home delivery

Place of Delivery Qualitative Study – Women's Narrative of Delivery Quotes from Samburu County

The population density in Samburu County is relatively low. The county-level rate of health facility delivery is well below the national average of 61%. The women's narratives of delivery quoted below give insight into what prompts women to shift their views on facility delivery and other nuances such as:

- Many women connect facility delivery specifically to a birth that has complications.
- One delivery experience likely impacts what women pursue with subsequent pregnancies.
- Preference for female health care providers is prominent, but not necessarily universal.

I have delivered children at home and these two small ones in the hospital.

The hospital is very good therefore I want to tell other women to deliver at the hospital. When you deliver at the hospital, you will be injected and you will not bleed.

When you deliver at home, you will not even wake. Then tomorrow you will not have energy because your blood has reduced and you have dizziness.

When you deliver at the hospital you will wake up tomorrow and wash your clothes. You have energy.

What that mother said about hating men it is true. My first child I delivered, I saw a man and told him what are you doing in a place that women deliver?

It is men who have delivered my babies, like these two. I had a Caesarean section and the two were removed. I was operated on in a hurry because if I was given time, I would have delivered normal.

I thank God, I liked the hospital. If I have another baby then I will just go to the hospital to deliver.

Female Focus Group Discussion Participant
Maralal Ward

Some will say a man cannot assist me while giving birth, others say I am not going to be tested and also there are those that generally fear the hospital to the extent of giving birth on their own at home.

Female Focus Group Discussion Participant
Loosuk Ward

PAR I experienced a sharp pain and my family called an ambulance. I washed and was rushed to the hospital. I gave birth at night. The doctor helped me during the whole process.

INT What are the advantages of delivering at the hospital?

PAR In the hospital you eat good food after you receive the injection but if you deliver at home you cannot eat.

In-Depth Interview Participant
Loosuk Ward

4.6 Turkana County

Census 2009 / KMHFL

- 6 sub-counties in the county
- 30 wards in the county
- 855,399 population
- 68,680 km^2 area
- 12 / km^2 population density
- 216 health facilities in the county

2014 KDHS

- 25% literate
- 18.9 median age at first marriage
- 6.4 mean number of children ever born
- 91% received ANC from skilled provider
- 23% health facility delivery
- 76% home delivery

Place of Delivery Qualitative Study – Women's Narrative of Delivery Quotes from Turkana County

The population density in Turkana County is relatively low. The county-level rate of health facility delivery is well below the national average of 61%. The women's narratives of delivery quoted below signify the influence of religion and cultural practices for women as well as other nuances such as:

- In some cases, religious beliefs carry more weight for women than evidence-based medicine.
- Strong beliefs exist in relation to the role of herbal medicines and specific medicinal foods.
- Birthing position and treatment of placenta align to specific cultural beliefs and practices.

When I was pregnant with my last child, the one who I told you is one year old, I used to go to the hospital.

Every time I went, they just lightly touched my stomach. Every time I tell them that I feel like the baby is up my chest. You know when I bend to pick something I cannot because I feel sharp pains in my stomach. They checked the child and said it is in the right position.

There was a day my mother was massaging me and she realized that the baby was facing upward. She could not do anything because it was already late.

When I went to labor, I went to Lodwar referral hospital. As I was lying down the nurse told me that the baby was not positioned well. She went to call the doctor in charge and he recommended I be taken to the operating theatre.

I said I will not do such thing. I will give birth normally because God is with me. As she was about to leave I felt the urge to push and called her. I gave birth normally but the baby's feet came out first. The nurse was happy.

Female Focus Group Discussion Participant
Turkwell Ward

They were worried about my pregnancy because I was very sick. I went to the hospital and they told me I had malaria. Even after medication, I was still sick and my feet swelled a lot. I was taken to Kalemjang hospital and we did not find any doctors.

I came back worried and knew it is only God who can help me. I started feeling better and I was even able to deliver at home. I had decided if things get worse, I should go and deliver in the hospital.

In-Depth Interview Participant
Lopei Kataruk Ward

Some women have no problems giving birth, they neither feel pain nor get complications. Such women just give birth at home.

Some women have a lot of complications, they bleed during pregnancy or get complications during delivery. Such women need to go to the hospital so doctors can help them.

In the reserves, they give such women herbal medicines and slaughter a goat for them. When she takes herbal medicines and the meat soup, she will feel better.

Female Focus Group Discussion Participant
Lopei Kataruk Ward

4.7 Analysis of Male-Only Focus Group Discussions

The data collection teams conducted eight male-only focus group discussions. These were conducted in four of the six counties and yielded 69 male participants (See Table 8). The analysis of these eight focus group discussions aims to explore the ways that male partners—specifically their views and degree of influence and involvement—represent a contextual factor that plays a role in how women experience and navigate the pregnancy-to-delivery continuum. In presenting the analysis in relation to five themes, part of the goal is to ensure consideration of both the potential positive and negative aspects emerging from male partner perspectives.

Theme 1: Advocates of health facility delivery or home delivery?

Most of the male participants appeared to share the belief that health facility delivery has advantages and is increasingly the desired approach. The participants noted that health facility delivery is important for the health of both mothers and babies, enables benefits such as ensuring that children have legal documents, and in some cases prompts access to food assistance programs. Often, the participants commented that health facilities are better equipped to deal with complications such as bleeding and prolonged labor, disease, and underweight babies, and have the capacity to provide vaccinations to newborns. The comments below from the male focus group discussions highlight these perspectives.

> *We longer have the issue of women delivering at home. We decided that the hospital helps because the main help is there. At home, there is no help that they can even add water or anything else it is not there.*
>
> **Male Focus Group Discussion Participant, Lembus Perkerra Ward, Baringo County**

> *It is dangerous because you can stay with a baby in the womb for too long, and the baby dies in the womb, and after some minutes of dying in the womb, the mother also follows. Rather they go to the hospital.*
>
> **Male Focus Group Discussion Participant, Keringet Ward, Nakuru County**

> *In the beginning, women had a very big problem because they delivered at home. The women will bleed and some even die because there are those from those communities who have died due to blood loss. This was a major problem. There were no clinics to take women to at that time.*
>
> **Male Focus Group Discussion Participant, Maralal Ward, Samburu County**

> *Some women go to the hospital to deliver because when food aid or any other donor projects come, the cards that they are given at the hospital is what they use to register people. They go there so they can get help later.*
>
> **Male Focus Group Discussion Participant, Turkwel Ward, Turkana County**

> *For us men, we are not so happy about delivery at home. She might give birth at home and get complications such as excessive bleeding and she needs to go to the hospital. We are happy about delivery at the hospital because as you continue with other duties of feeding the family, you are sure that she is well taken care of.*
>
> **Male Focus Group Discussion Participant, Lopei Kataruk Ward, Turkana County**

> *We are happy about woman delivering in the hospital because we know that when she delivers at the hospital, she can be treated in the hospital and the baby is also registered and this helps when they baby grows up and they need that birth notification card in school.*
>
> **Male Focus Group Discussion Participant, Lopei Kataruk Ward, Turkana County**

The male participants appeared to be aware of possible concerns and fears about health facility delivery. For example, a participant in Nakuru County noted that women sometimes fear a health facility delivery will result in having an operation, and a participant in Turkana County noted that women sometimes fear receiving treatment from a male doctor.

> *Nowadays when a woman has labor she is not given time, she will be operated on quickly. She will be told you are going to be operated on. They are rushing into it and they end up hurting women for no reason. This has become too much in the hospital.*
>
> **Male Focus Group Discussion Participant, Keringet Ward, Nakuru County**

> *When a woman delivers at the hospital, she will be helped maybe by a male doctor. When she goes to the village and narrates her story, others will refuse to go and give birth at the hospital because they do not feel comfortable being helped by a male doctor. They prefer a female one.*
>
> **Male Focus Group Discussion Participant, Turkwel Ward, Turkana County**

In some cases, advocacy for health facility delivery from a male partner carried a side motivation with potential harmful consequences, as exemplified in the comment below from a participant in Samburu County.

> *I have also noticed that if you compare women who deliver at home and hospital have different healing times. The ones delivering at the maternity heal faster than the women who deliver at home. The ones from the hospital start working earlier than their counterparts.*
>
> **Male Focus Group Discussion Participant, Loosuk Ward, Samburu County**

Data from the eight male-only focus group discussions suggest that men are generally advocates of facility delivery for their wives. In particular, the male participants appeared to be aware that a health facility is a safer place of delivery and a better site to access services.

Theme 2: Home birth still occurs given the prominence of TBAs

A number of the male participants offered reasons why home birth continues, and in some cases is preferred. They said that TBAs provide massages for pregnant women, through which they can help position the baby for birth; deliver and dispose of the placenta in keeping with tradition; stay with women throughout their labor; and at times can be the person to refer women to the hospital. The comments below from participants in Nakuru, Samburu, and Turkana Counties provide a sense of the prominence of TBAs.

> *A pregnant wife wants to feel the position of the baby in the womb. She goes to an old woman to feel and straighten out and put oil. Then the baby will sit in the right position in the womb.*
>
> **Male Focus Group Discussion Participant, Keringet Ward, Nakuru County**

> *When the TBAs massage their [the woman's] stomach, they tell them the baby is well and reassure them about the same. They do not see the need of going to hospital. The women have freedom, they decide for themselves if they want to go to the hospital or not.*
>
> **Male Focus Group Discussion Participant, Loosuk Ward, Samburu County**

> *Let us divide these ways into two. When a woman sees that her body is not good, maybe she is tired or something, she can go to the village and be massaged by the old women. They may realize that that the baby is not good and help her. Another can go to the hospital for treatment. They test her and if the baby is not well, she will be given drugs that will treat her so that she can be healthy again.*
>
> **Male Focus Group Discussion Participant, Turkwel Ward, Turkana County**

> *When a woman gets pregnant, they see themselves and weigh their bodies. If they are strong, they will see no need in going to the hospital to deliver because they believe in themselves.*
>
> **Male Focus Group Discussion Participant, Turkwel Ward, Turkana County**

Data from the eight male-only focus group discussions suggests that male partners are aware of the benefits of health facility delivery, but also aware of why women seek services and support outside of health facilities. In particular, they see that women hold TBAs in high esteem, and this perspective potentially influences choices about place of delivery.

Theme 3: Common challenges and hesitancies associated with health facilities

Across the male focus group discussions, the participants emphasized that lack of transport creates a challenge for accessing health facilities. Further, the discussions suggest that beginning labor during the evening or needing care at night amplifies the transportation challenge. Participants in Nakuru and Samburu Counties explained that lack of transport potentially results in home delivery.

> *It may be that in some homes the baby is born at midnight, she can have labor the whole day, then suddenly the baby is born at night. There is no means to go anywhere. This means you have to rush and get the mothers of certain elders and bring them here so they can check on her as she delivers at home.*
>
> **Male Focus Group Discussion Participant, Eburu Mbaruk Ward, Nakuru County**

> *A lot of women know about hospitals but there are many who are delivering at home due to long distances to hospital hindering women to go to hospital, therefore they deliver at home. A woman may start having labor pains and the hospital is far so she just gives birth at home.*
>
> **Male Focus Group Discussion Participant, Loosuk Ward, Samburu County**

Nearly all of the participants described experiences where health care required payment, including bribes and payments due to other forms of corruption. The consensus among the participants was that without providing money and/or having a personal connection or shared tribal identity with health facility staff, people could end up stuck waiting in long queues and risk possibly dying while waiting for care.

The participants referenced HIV as both a driver for health facility delivery and a cause of fear that deters some women from health facility delivery. The comments below from participants in Baringo, Nakuru, and Samburu Counties exemplify the range of views about how HIV influences pregnancy and place of delivery choices.

> *Like the current disease HIV. People have fear that if I do not have it, because went to clinic to be tested. How do I know about the person who will help me deliver at home? So, they prefer the hospital, they know it is safe.*
>
> **Male Focus Group Discussion Participant, Lembus Perkerra Ward, Baringo County**

They like to deliver at home if they want to hide their health status. Maybe she knows she has HIV/AIDS, so she will not go to the hospital.

Male Focus Group Discussion Participant, Keringet Ward, Nakuru County

Delivery at the hospital is better because when you deliver at home, even those women who assist at home you know she does not have gloves. She may assist and infect your wife with HIV/AIDS. It is better there is protection, even cutting this thing [the umbilical cord]. The hospital is better.

Male Focus Group Discussion Participant, Keringet Ward, Nakuru County

Not all of us will understand the type of diseases they are suffering. Instead of seeking treatment early, many of us ignore or even we fear to seek treatment in hospitals because you may find you have terminal diseases and this will increase stress. They have become too much until you feel like HIV is becoming better. We have cancers or Ebola, so people fear if a disease is discovered, and they were surviving before, they might be stressed and die early.

Male Focus Group Discussion Participant, Loosuk Ward, Samburu County

The male focus group discussions provide evidence that women often tell their male partners about the type of treatment they receive in health facilities. In particular, the male participants noted that many women seem hesitant about health facility delivery due to poor treatment from the health service providers. The comments below from participants in Baringo and Nakuru Counties highlight the types of experiences that women describe to their male partners.

She is not happy because you hear when they go to the hospital during delivery there is harassments from the doctors. Maybe being beaten. Things like that are the challenges that they go through.

Male Focus Group Discussion Participant, Ravine Ward, Baringo County

Nowadays nurses instead of talking to you in a good way, they can shout at you, saying why did you do this and such. She [the patient] will not ask anything she wanted to ask, she will fear. If she got there and was treated in a good way, she will not fear to ask.

Male Focus Group Discussion Participant, Lembus Perkerra Ward, Baringo County

It is bad especially at the government hospital. They say they are abused a lot. Sometimes they even refuse to go to a private hospital. When they go there, most of the times you find that they are tormented there.

Male Focus Group Discussion Participant, Eburu Mbaruk Ward, Nakuru County

It is like this. Some are young. They have not ever delivered when the doctor looks at them. They are afraid. When they go there [to a health facility], they are told get your clothes off. She is afraid and has a problem.

Male Focus Group Discussion Participant, Keringet Ward, Nakuru County

Data from the eight male-only focus group discussions suggest that awareness of the benefits of health facility delivery does not automatically translate to actually delivering in a facility. The participants provided a range of examples highlighting common challenges and hesitancies associated with health facilities, including lack of reliable transportation, long waits, lack of drugs, unexpected fees, concern about the belief that HIV testing is required, and lack of respectful and culturally sensitive care.

Theme 4: Decision-making about place of delivery

The data suggest that male partners tend to advocate health facility delivery. However, in some instances their advocacy involves asserting themselves as the decision-makers, as opposed to involving themselves in day-to-day health-related activities such as accompanying their pregnant partner to a health facility and offering emotional support. Several of the male participants noted that they might consult with their wives about place of delivery, but ultimately, the husbands have the final decision. The comments below from participants in Nakuru County demonstrate an assertion of male decision-making authority.

> *When she gets pregnant you sit down and start planning and deciding. You start saving up on assets that she may use, you start up slowly. Like what this man has said, she will not talk. It is you [the male partner] to start planning, and take her to the hospital, and it will be good when she delivers.*
>
> **Male Focus Group Discussion Participant, Eburu Mbaruk Ward, Nakuru County**

> *I can contribute if she made a mistake and went to the wrong direction. If I see it is a big problem, I will personally have to tell her no, where we were going is here because at other times she may want for us to go to the dispensary and what difference is at the dispensary? We would rather go to a big hospital and be attended to over 2 or 3 days before she is released.*
>
> **Male Focus Group Discussion Participant, Keringet Ward, Nakuru County**

Views on decision-making varied considerably across the eight male-only focus group discussions. Several of the participants stated that women make the decisions about place of delivery, and may do so based on the advice of other women or in consultation with their mother or mother-in-law. The presence of mixed views on decision-making supports the notion that decisions—whether the domain of men, women, or men and women together—generally represent a process of navigation and negotiation.

Theme 5: Types of male partner involvement in maternal health matters

Most of the male participants showed some knowledge of and interest in maternal health. Often, the participants said that attending to maternal health falls primarily in women's domain; however, a few deviated from this gendered view of maternal health. The comments from participants in Baringo and Samburu Counties suggest that, for some men, involvement from male partners in maternal health is important and warrants further attention.

> *INT: And in your opinion, do you think it is important for a woman to be accompanied by her husband when going to seek healthcare services at the clinic when she is pregnant?*
>
> *PAR: It is important because when she sees the doctor, you [the husband] will be there too. You are told this is bad while this is good. You get to know the health of the baby, the health of the mother.*
>
> **Male Focus Group Discussion Participant, Ravine Ward, Baringo County**

> *People still have ignorance and compare things to the past. It will be good if we had a joint training so that both the men and women know about it [maternal health]. We need men to know this because it was assumed to be the woman's responsibility.*
>
> **Male Focus Group Discussion Participant, Loosuk Ward, Samburu County**

Male partner involvement in maternal health can take a variety of forms and occur to varying degrees. Across the male-only focus group discussions, the participants often described forms of involvement in terms of protecting women, providing food for women, and helping women lessen their workload.

Often, the statements tended to be authoritative in tone. The comments from participants in Baringo, Nakuru, and Turkana Counties give an indication of this type of male involvement when women are pregnant.

> *I said you can look for someone to help but like me, I usually help her. I prepare food.*
>
> **Male Focus Group Discussion Participant, Lembus Perkerra Ward, Baringo County**

> *It is just staying at home and not doing a lot of heavy duties like going to fetch water or going to the shamba [field] or going to herd cattle and standing in the sun. She can be given time to rest. There are some [women] that get hurt because they do not have helpers.*
>
> **Male Focus Group Discussion Participant, Eburu Mbaruk Ward, Nakuru County**

> *When a woman is pregnant, the only thing she is required to do is to cook. If she has a business, she provides services such as selling. She is not supposed to do heavy work like cultivating and carrying heavy objects.*
>
> **Male Focus Group Discussion Participant, Lopei Kataruk Ward, Turkana County**

Other possible forms of male partner involvement in maternal health during pregnancy center on visiting the health facility with their wives, participating in discussions with health service providers, and in general adopting a more proactive engagement and investment in day-to-day preventative, management, and care activities. A participant in Samburu County described his involvement in this way, and in certain ways he provides a narrative of delivery from a male perspective. Overall, however, the data suggest that male involvement to this extent may not be the norm.

> *The importance I see is when a woman goes to clinic she is weighed. Also, she is understood that she is pregnant, she will be checked if she has enough blood that can sustain her during pregnancy or if she has strength to carry that pregnancy.*
>
> *When my wife went there [health facility] it was noticed she did not have enough blood. When she came home she was given medicines that will give her strength. She was given a note to instruct me that when she goes back we go together. When we went back, her blood was not up; therefore, she had to be admitted.*
>
> *The doctor counselled me and told me that this was my responsibility. I should not be far from her. The reason for her blood count not increasing might be a lot of stress. You should stay with her, feed her, get fruits and her blood count will be up. He also said that when the mothers do not go for clinic she will not be dewormed and worms will affect her and she will be weaker.*
>
> *Also, when she has dependent infections, like malaria, she becomes weak. We had to follow up on her until delivery. She had a problem again. She stayed longer until the doctor had to be called so that she can be operated on because the baby was breech. After the caesarean, the baby was safe and the mother was also treated well.*
>
> *If I would have stayed with her at home I would have lost both of them so that is why I have contributed that it is important to be near to the doctors and as men we should support our wives.*
>
> **Male Focus Group Discussion Participant, Maralal Ward, Samburu County**

In a few cases the participants described male partner involvement in maternal health in ways that might cross over into negative or harmful practices. For example, several participants said that keeping a distance from pregnant women is important for the women's health. In addition, involvement from a male partner can potentially create an uneven power dynamic to the extent that a woman has limited voice in matters relating to her own health. Participants in Baringo and Nakuru Counties hinted at this type of potential male misrepresentation and control.

You as a husband should not come close to her. Get busy with your things that will be safe to her. That will help her because it is not a must that you stay with her that close. You should even have separate beds such that it is you in your bed and her in her bed. Just let her relax and take care of her baby.

Male Focus Group Discussion Participant, Ravine Ward, Baringo County

The husband should be the teacher to the wife. When you are the teacher to the wife, she will be healthy. She will not have many diseases. It will help with making her feel happy in her heart.

Male Focus Group Discussion Participant, Eburu Mbaruk Ward, Nakuru County

In a few cases, the participants raised the possibility that men sometimes feel an unplanned pregnancy is the woman's fault. Views of this type, noted below from participants in Baringo County, create challenges for women and potentially influence the health care strategy during pregnancy and the choices pertaining place of delivery.

When they are pregnant you find that they want a keeper. Maybe they had not planned themselves with the husband. Maybe they were doing their hustle. Sometimes you find the husband saying no we had not planned so that mother will have a problem maybe of food, shelter because she is not getting the income.

Male Focus Group Discussion Participant, Ravine Ward, Baringo County

There are those that emerge, someone goes and gets pregnant. These young people who are not a family yet, so she will be taken to maternity and the last thing is this stomach, when she is going to get help at the hospital. When she gets to the hospital, she delivers and leaves the baby that he refused, so she says this person has another wife at home and he lied to me, so I will leave the baby here and he can come for it.

Male Focus Group Discussion Participant, Lembus Perkerra Ward, Baringo County

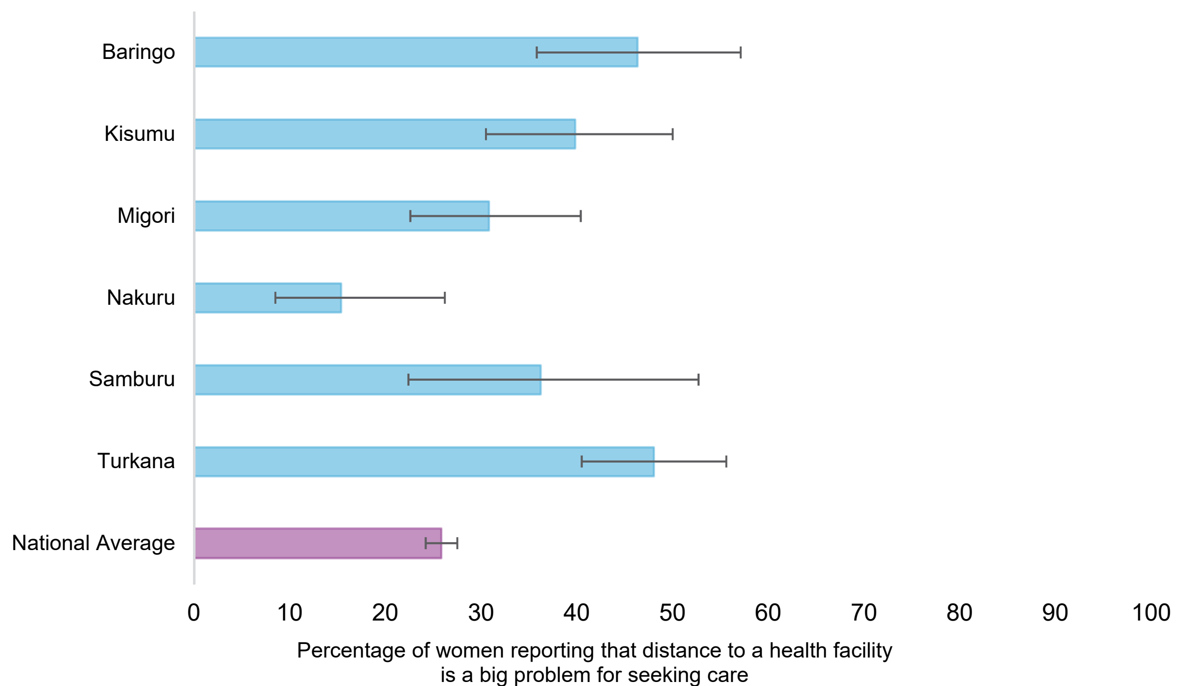
Beyond providing evidence of men's general knowledge of maternal health, the discussions contain a wide range of examples of types of involvement in maternal health from male partners. Some types of involvement are positive, such as sharing household chores or accompanying a pregnant partner to a health facility. In addition, the data reveal that a male partner's involvement in maternal health could potentially have negative consequences insofar as it might work to create or further entrench power over a female partner.

The analysis of the eight focus group discussions has positioned the maternal health-related actions (or lack of action) of male partners as a contextual factor influencing the pathway of women during the pregnancy-to-delivery continuum. With each of the five themes, the goal has been to highlight that the views of male partners as well as the degree and ways they are involved—whether as a staunch advocate of facility delivery, a thoughtful contributor to decisions, or a distant observer during pregnancy—carry weight in women's lives and how they engage in health-related strategies.

4.8 Geographic Challenges Reported across the Six Counties

Secondary analysis of the 2014 KDHS examined variation and sociodemographic inequities in maternal health indicators. This analysis suggests that health facility access is inequitably distributed across counties (Mbugua and MacQuarrie 2018). As Figure 3 shows, in five of the six counties examined in this qualitative study, the proportion of women reporting that distance to a health facility is a problem for seeking care is above the national average.

Figure 3 Distance to health facility by county, 2014 Kenya DHS



Across the in-depth interview participants, the mean distance from the nearest health facility was 3.0 km (see Appendix 3.1), a seemingly manageable distance even in more rural areas where cars and public transportation are limited. It is important to keep in mind that the findings from the in-depth interviews are self-reported by the participants, who may understand the term "health facility" differently; however, the combination of data from the two studies helps focus attention on the likely complex interaction of factors that play a role in geographic accessibility to health facilities and skilled attendance at delivery.

Across the six counties, many participants reported that when the distance to the health facility was too far, they would instead deliver at home with a TBA. Some participants said that distance was their only barrier to health facility delivery. Participants who had been transferred from one facility to another noted the financial challenge associated with needing additional transport as a barrier. In some instances, participants indicated that the nearest facility did not have maternity services; therefore, there was a need to travel to a facility further from their home. The statements below from participants in Kisumu and Nakuru Counties exemplify how distance to a health facility generally influences decisions on whether to deliver at home or in a health facility.

> *Sometimes labor pains begin in the morning, and when it reaches midday, you say you want to go to the hospital. On reaching the hospital the doctor tells you that you are still far from delivering just go back home. When you come back home, you still have the labor pains and now they are severe. Within no minutes, you see the amniotic fluid coming out. You just decide to deliver at home because there is nothing much you can do.*
>
> **Female Focus Group Discussion Participant, North West Kisumu Ward, Kisumu County**

> *The challenge is most of them [women] they come from far areas and hard-to-reach areas. They decide maybe to deliver at home instead of coming all the way to the facility. Sometimes when they try to deliver at home then maybe they face some challenges like bleeding, complications, retained placenta.*
>
> *There are those who will say let me go and just check. But, some do not come because they know if they come, maybe they will not find someone to help them. Then they have already left home already in labor so they cannot go back home. Instead, they will go to private and private is very expensive.*
>
> *Often women feel it is better I stay at home and deliver from home in case I go to the facility and I do not get anyone. Because I have already left, maybe I can give birth on the road. There are a lot of risks. But, when she is there she has the TBA she has everything, what she needs, so she feels let me just stay at home. Deliver knowing rather than delivering going around in the facility I do not get any staff to help me then I will have to go to private.*
>
> **Key Informant Interview Participant, Eburu Mbaruk Ward, Nakuru County**

Distance to the health facility is also relevant to TBAs. For example, a key informant interview participant from Samburu County who is a TBA noted living near a health facility provides women (her clients) with options in the event of complications.

> *I am lucky because where I am working is next to the referral hospital. When I get mothers with complications, I refer them. We ask for help from the referral hospital with an ambulance. There are also matatus [mini buses used as public transportation]. The place is so busy, the road is so busy maybe you can talk with them and they can assist. The hospital is just close, it is less than 5 kilometers.*
>
> **Key Informant Interview Participant, Maralal Ward, Samburu County**

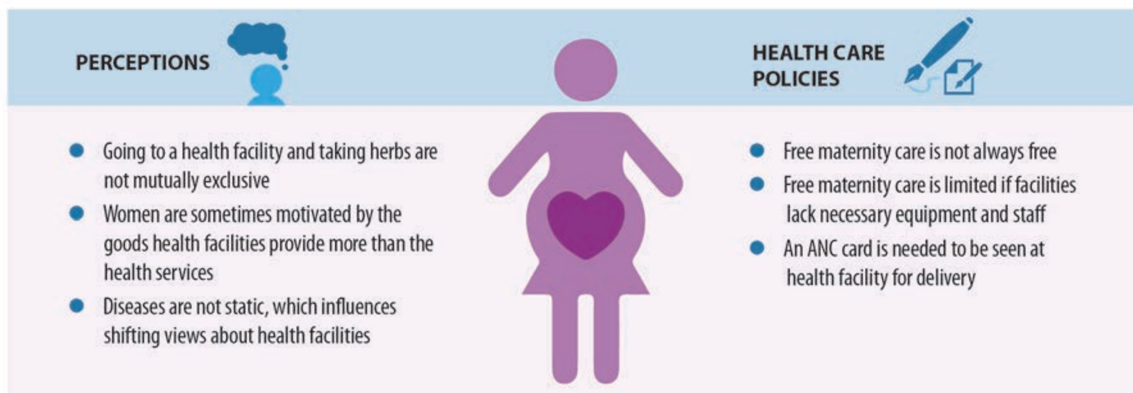
Transportation challenges relate to more than simply distance and geography. Many participants reported that arranging transportation once in labor might pose a challenge given the short notice. There were also added barriers during the rainy season due to muddy roads and the fear of having an accident. A large number of participants reported that due to poor roads they had to take motorbikes to health facilities, which was identified as particularly challenging when in labor.

In many instances labor begins after dark, and participants often said it would be dangerous to travel at night to a health facility. Willingness to travel after dark would not necessarily resolve the issue, as many participants noted that often no doctors are available outside of regular facility hours. As such, awareness that there may be no health care providers available at night sometimes leads women in labor to wait until morning to travel to a health facility. Participants noted that often delivery happens before morning.

4.9 Conclusion

This chapter considered the data from three perspectives. First, the county-by-county women's narratives about delivery explored women's individual experiences. Next, the analysis of male-only focus group discussions focused on maternal health from men's perspectives, including the varying types of male partner involvement. The chapter ended by emphasizing how geography and transport can pose major challenges to accessing health facilities. Collectively, these three perspectives provide a foundational and contextual starting point. Chapter 5, which follows, focuses on health care in a broad sense, with specific emphasis on the link between women's perspectives on health services and health facilities and their actions and choices relating to pregnancy and delivery.

5 HEALTH CARE PERCEPTIONS AND POLICIES



Before delving into the findings specifically about the journey across the pregnancy-to-delivery continuum, it is valuable to examine the broader topic of health care. How women experience and navigate health services and health facilities in general plays a role in their actions and choices relating to pregnancy and delivery. As such, this chapter examines the perceptions among the study participants regarding health care broadly and in consideration of health care policies advanced by the Government of Kenya. Past research and existing literature support the reality that place of delivery is a decision that women make in some cases, while in other cases the decision is made for them based on the onset of labor. Further, programs and policies that promote optimal health practices importantly account for the reality that barriers to success can be due to both structural or systemic circumstances as well as the behaviors and choices of individuals.

5.1 The Dual Roles of Biomedical and Traditional Approaches

The KMHFL data indicate there are 1,397 health facilities across the six counties selected for this study. The number and types of health facilities[2] vary among the six counties, as does the population and population density. In broad strokes, Kisumu, Migori, and Nakuru Counties are densely populated and have 226, 223, and 451 health facilities respectively, including 22, 12, and 25 level-4 health facilities. Baringo, Samburu, and Turkana Counties are not densely populated and have 209, 72, and 216 health facilities respectively, including 4, 2, and 10 level-4 health facilities. Appendix 6 provides a summary of the number and types of facilities for the six selected counties.

The focus of this study is individuals (primarily women) and their beliefs about pregnancy, place of delivery, health services, and health facilities, and not a clinically or biomedically framed assessment of health facilities. However, noting KMHFL data in a broad sense is important context as part of recognizing that in each of the six counties health facilities are present and the Government of Kenya has a system in place to record and track the number and types of health facilities.

[2] Type of health facility is in relation to the services provided, with health facilities categorized as level 1-4 as defined by the Kenya Ministry of Health (see Chapter 1).

Data from the study suggest interest among participants in seeking services at health facilities. As Table 9 shows, the in-depth interview participants generally responded favorably to the yes-no questions regarding health services. To a certain extent, women who reported that their last delivery was in a health facility tended to have more positive perceptions of health services compared with women who reported that their last delivery was at home.

Table 9 Perceptions among in-depth interview participants regarding health services, by place of last delivery

Question	Place of Last Delivery = Home			Place of Last Delivery = Facility		
	% Yes	% No	N	% Yes	% No	N
Do you think sufficient hospitals exist in this community?	24.1	75.9	29	43.3	56.7	30
Do you think hospitals are easily accessible in this community?	51.7	48.3	29	73.3	26.7	30
Do you think hospitals in this community provide good services?	65.5	34.5	29	83.3	16.7	30
Do you trust service providers at hospitals?	75.9	24.1	29	79.3	20.7	29
Have you ever felt afraid about going to a hospital?	29.6	70.4	27	24.1	75.9	29
Has anyone ever discouraged you from going to a hospital?	20.7	79.3	29	20.7	79.3	29
Has anyone ever encouraged you to go to a hospital?	78.6	21.4	28	96.7	3.3	30
Do you think women in this community commonly go to a hospital for treatment?	78.6	21.4	28	85.7	14.3	28
Do you think women in this community commonly seek treatment outside a hospital?	46.4	53.6	28	51.9	48.1	27

This indication of general favorability, however, does not preclude favorable views about traditional approaches, notably the use of herbs. Across all six counties, the participants routinely discussed the role of herbs in treating illnesses and as part of beliefs about maternal and child health care. The degree of commitment to herbs varied among the participants. The statements below from participants in Migori and Turkana Counties, for example, indicate belief that certain ailments are local and require treatment with local herbs.

> *The local diseases are fibroid. You might go to the hospital and when you come back even after injection it is still there. It will force you to go to the TBA to get herbal medicine so you can drink. To make that fibroid to disappear.*
>
> **Focus Group Discussion Participant, South Kamagambo Ward, Migori County**

> *There are some diseases that are local and you might need to be treated locally like one called lokou, they slaughter a goat and also give you some herbs.*
>
> **Female Focus Group Discussion Participant, Turkwel Ward, Turkana County**

Across the six counties, the participants often described the commitment to herbs in relation to both an approach to health care and a belief in honoring cultural traditions. A key informant interview participant from Turkana County explained the challenge for health care providers when beliefs in herbs are entrenched among community members.

INT *How do they feel about seeking treatment for themselves?*
PAR *They take it positively because they know they can be treated well. The problem however is that they usually run for the traditional medicines first. They do not believe that the drugs in the facilities are better than the traditional medicine. The moment the traditional medicine fails is when they now decide to go to the facility. What we usually do is, we flush the traditional medicine out of her body then we can now give the medicine in the facility. We do this through a special fluid.*
INT *Do family member have an influence on the decision of women on seeking medical treatment? If yes, which kind of influence do they have?*
PAR *Yes they do. Turkana men for instance believe in herbs so much because they have used it before and they were able to recover. They tell their women to use the herbal medicines. As the head of the household, they have a bigger influence on their women and they tell them to go for herbs because that is what they also use.*
INT *Is their influence very strong?*
PAR *It is very strong because they are the husbands.*

Key Informant Interview Participant, Lopei Kataruk Ward, Turkana County

In many instances, the participant's statements reflect a blending of beliefs and approaches, with biomedical and traditional approaches co-existing rather than being a matter of only one or the other. Herbs might be the first option, as noted below by a participant from Baringo County, or the second option if treatments received from a health facility are not working, as noted below by participants form Kisumu County.

PAR *Maybe we have our grandmother here who tells you eat this and this. You go to dig for sure and you eat and you see that you get well.*
INT *So, in your view, you see that sometimes?*
PAR *The traditional one helps you. You know the traditional one does not have side effects.*
INT *The traditional one does not have side effects?*
PAR *Yes. This hospital medicine that you swallow, where does it go and you do not get well? You know the body becomes resistant.*
INT *So, in your view, you see that…*
PAR *Sometimes it is good to change. So that you even break the monotony of Panadol.*

In-Depth Interview Participant, Lembus Perkerra Ward, Baringo County

If there is no improvement in the hospital that is when you will decide to go to the church to be prayed for. Then after going to the church elders and you are not able to get any improvement, that is when you go to the traditional herbalist to give you herbs.

Female Focus Group Discussion Participant, North West Kisumu Ward, Kisumu County

The statements below from participants in Baringo and Samburu Counties highlight the potential risks associated with seeking a combination of biomedical and traditional medicines. In the first example, the participant appears to be aware of the potential risk whereas in the second example it seems the participant is unaware.

When he gives me traditional herbs I will boil and I will drink, yet I have not asked for instructions from the doctor. You know it is important to ask instructions from the doctor because he is the expert. That traditional expert will just touch here and say I feel here is bad. The expert doctor has an instrument for testing that sees the all body and he will know. Now you find a traditional expert who will just touch you here and say this drug will help you, and already you have drugs from the hospital so you see already you have a problem. And that problems comes from mixing traditional herbs with medicine from the hospital. My advice is if people can be educated they should listen to the doctor, the doctor is a very important person. He is our second God.

Male Focus Group Discussion Participant, Ravine Ward, Baringo County

There is a time I went to hospital, if the herbs fail to treat me. I leave the herbs and go to hospital and tell the doctor that I am sick. Then the doctor test me and give me medication. But, first I make sure that I used herbs before going to hospital. But, I do not tell the doctor that I took herbs I just tell the doctor am sick.

In-Depth Interview Participant, Maralal Ward, Samburu County

Data from the study suggest a wide variety of views and implications associated with the dual roles of biomedical and traditional approaches. In many cases the comments from participants seem to indicate that the presence of health facilities and advocacy to seek health services at health facilities may not be effective or appropriate if simply juxtaposed as “better” alternatives. Rather than trying to change deeply rooted beliefs about traditional approaches, many participants in the study referenced a desire to blend traditional and biomedical approaches.

5.2 Biomedically Defined Quality of Care Not the Only Factor

Data from the study indicate that women’s perceptions and motivations around heath care services and health facilities may not necessarily have a biomedical basis. Across all six counties, the participants often described health facilities as sites to have access to and receive goods in addition to health services. Goods such as food, a bed, clean sheets, mosquito nets, and clothing for a newborn appeared to be valued. The participants often characterized these goods as benefits associated with seeking care in a health facility. In some cases, gaining access to the goods, as opposed to receiving optimal health services, appeared to be the singular motivating factor in a decision to seek care at a health facility. The comments below from participants in Baringo, Kisumu, and Samburu Counties reflect this perception.

I was in western Kenya. I saw women who have delivered, those people from mission had gone to visit, they were given clothes, and also food in the paper bag, there is a way you will be brought fruits, milk and there are people who will do laundry.

Female Focus Group Discussion Participant, Ravine Ward, Baringo County

INT: Are there services or treatments you wish you would have received [at the hospital]?
PAR: I wished they bought me baby clothes.

Female Focus Group Discussion Participant, North West Kisumu Ward, Kisumu County

I will not gain anything for delivering at home but the other who will deliver at the hospital will get clothes.

In-Depth Interview Participant, Maralal Ward, Samburu County

As a female focus group discussion participant from Kisumu County noted, participants sometimes referenced lack of goods in relation to being dissatisfied with health facilities.

There is some water they are supposed to bring for you in the morning for bathing that one is brought at nine, second there is breakfast that is brought late.

Female Focus Group Discussion Participant, Kisumu West Ward, Kisumu County

In a general sense, comments about receiving or not receiving goods appeared to position both the goods and the visit to the health facility as signs of prestige. Further, while many participants described seeking care at a health facility as ideal, these descriptions often did not define "ideal" in biomedical terms or even as related to biomedical knowledge. Instead, many participant statements tended to be a mix of broad-based awareness of health care matters and re-statements of advice or guidance they heard from family members or health service providers. The number of ANC visits and the motivation for these visits reflect this limited biomedical knowledge dynamic.

As Table 7 presented (see Chapter 3), among the 60 in-depth interview participants 10% reported making no ANC visits during their last pregnancy, and 58% reported making at least four ANC visits during their last pregnancy. This latter finding aligns to data from the 2014 KDHS showing that at the national level 58% of women made at least four ANC visits during their last pregnancy (KNBS 2015). Understanding what motivates women to make ANC visits is an important aspect of interventions to increase ANC visits.

Data from the study indicate a wide range of motivations. One prominent motivation was in relation to the importance of having an ANC visit documented to ensure access to future health services related to pregnancy and delivery. Statements from participants in Baringo, Kisumu, and Migori Counties are emblematic of the ways the motivation to make ANC visits in some instances is not necessarily centered on pursuing ANC for the mother and baby in that immediate moment.

I had to go to the hospital so that I could get the clinic card, when the delivery day comes when you do not have that card you will have a problem.

In-Depth Interview Participant, Lembus Perkerra Ward, Baringo County

INT	*Did you go for ANC?*
PAR	*Clinic?*
INT	*Yes.*
PAR	*I only went once when I went to take a book, I never went back again.*
INT	*Why did you go to the clinic?*
PAR	*I went to get a book, I went when I had a headache and that is when I was told to go to the clinic to be tested.*

In-Depth Interview Participant, North West Kisumu Ward, Kisumu County

Because I had to look for a card because I might deliver, and I do not have the card now my delivery can become complicated and I end up being transferred to the major hospital and you cannot be treated without the card. Yeah that is the reason.

In-Depth Interview Participant, Central Kamagambo Ward, Migori County

The desire to obtain an "ANC book" largely as assurance of future care is striking in the findings across the six counties. Only rarely did in-depth interview participants describe some of the ways in which an ANC book is also a health education tool. However, with many participants reporting multiple pregnancies, it is evident that women come to understand the benefits of ANC services over time. As noted in the comment below from a participant in Turkana County, previous experience provides a pathway for improving one's understanding of health care options and services in biomedical terms.

INT	*What influenced your health care decisions, like going for ANC during your last pregnancy?*
PAR	*I have been having difficulty during my deliveries. The placenta is always retained inside. I have to deliver at the hospital. Also, I go to the hospital so I know how my child is developing.*

In-Depth Interview Participant, Turkwel Ward, Turkana County

Health service providers receive biomedically based education, and in the course of their work in health facilities often tend to explain health matters in biomedical terms. Findings from the study suggest that people seeking care in health facilities do not necessarily think about their own health, or health in general, in biomedical terms comparable to those used by health care providers. For service providers, recognizing this possible disconnect can be an important element of relating to people seeking care in health facilities on their own terms.

5.3 Navigating Shifts Over Time and the Role of a Health Facility

Data from the study suggest a high level of awareness and insight among participants regarding the ways beliefs about health, diseases, and options for treatment have shifted and changed over time. For example, in the statement below a participant from Kisumu County describes her own internal thought process and tension regarding beliefs from the past about treating measles.

You know there are people when they see the baby has measles and they tell you for measles do not take the baby, just take some herbs and crush and give the baby. But, you as a parent you keep thinking, I have to take my baby to hospital, isn't she sick, so there is difference because they tell me to crush herbs while I say that I should take to hospital.

Female Focus Group Discussion Participant, Kisumu West Ward, Kisumu County

A male participant from Samburu County demonstrates similar insightfulness in reflecting on the ways disease is not static; therefore, treating disease also cannot be static.

In most cases, the people used herbs; that is what they believed most and now it has changed and hospital is the most preferred. We have also seen that infections have now become more in the world. One contacts an infection and it changes to something else so you cannot treat it at home.

Male Focus Group Discussion Participant, Maralal Ward, Samburu County

Across the six counties, the participants described both negative and positive experiences at health facilities. In both cases, there often seemed to be a strong sense, an almost blind faith, that biomedical approaches differ from traditional approaches, given their focus on testing and diagnostics. The statements below from participants from Baringo, Nakuru, and Turkana Counties exemplify this type of awareness about an increasing presence and presumed superiority of biomedical approaches, including both positive and negative reactions.

You are not supposed to just swallow any drugs and you do not know yourself. Nowadays there are so many diseases and if you swallow a painkiller if it works for that disease may not be quickly known. It is better to go to hospital, get tested and be given good medicine that is for that disease.

In-Depth Interview Participant, Ravine Ward, Baringo County

> *Some people are contemptuous because they say that when they go there [the hospital], they do not see any important medicine that people are given. It can be that you have malaria, and another has a certain disease, maybe stomach ache. You are all given capsules the same type all of you.*
>
> **Male Focus Group Discussion Participant, Eburu Mbaruk Ward, Nakuru County**

> *I see that outside, the drugs that a person is given, no one has measured them. They can tell you to take like a whole jug and maybe it's excess and cause more harms. They have not measured them like the ones for the hospital where they tell you to take Panadol three times a day.*
>
> **Male Focus Group Discussion Participant, Lopei Kataruk Ward, Turkana County**

In many instances, the participants stressed that health facilities increasingly provide more than just services. The opportunity to receive training, written information about optimal health practices, and benefits from health-related promotions or campaigns was described favorably. The statements of participants from Baringo and Migori Counties highlight common expectations.

> *Campaign services and free scanning, diabetic tests and blood pressure. That really helps when they call for such campaigns, it's free of charge, they have helped us.*
>
> **Female Focus Group Participant, Ravine Ward, Baringo County**

> *The positive I see is that, at times, when we go to the hospital you find them training [the women] before giving medication. Especially expectant women you will find they organize a session even once a week to train them on the benefits of delivering at the hospital, disadvantages of delivering at home, and the benefits of visiting the clinic. They also give medicines that one needs to take when expectant or when having malaria. People are trained on the benefits of sleeping under a net. Those are some of the things people are trained on.*
>
> **Focus Group Discussion Participant, South Kamagambo Ward, Migori County**

In the context of expecting health facilities to have an expanded role, for some participants that expansion included facilitating increased thinking about health care, pregnancy, and delivery in both preventative and aspirational ways, as noted below by participants from Kisumu and Samburu Counties.

> *At the TBA we are normally given herbs. At the hospital there is an injection. That injection is meant to protect the child's health. We are given multivitamin and there are some other drugs that they normally give us. That is why most women see that it is good to go to the clinic.*
>
> **In-Depth Interview Participant, North West Kisumu Ward, Kisumu County**

> *I have not delivered in hospital but those who have say that when you deliver in hospital, an ambulance picks you, you get skilled birth attendance, you will be given baby clothing and you will be treated in case of any complications arising after birth, thereafter brought back home with the ambulance.*
>
> **In-Depth Interview Participant, Maralal Ward, Samburu County**

Data from the study indicate relatively high levels of awareness among participants that health care professionals advocate seeking services at health facilities (see Table 9). As such, preventative and aspirational thinking are important to recognize and encourage.

5.4 Perceptions Impacted by Corruption, Low Capacity, Hidden Costs

Many female participants stated that they often faced corruption when procuring services at a health facility. For example, the comments below from participants in Baringo, Migori, and Nakuru Counties indicate a belief that providers unjustly benefit financially at the expense of the patient, whether it be overcharging for some services and/or charging for services intended to be free of charge.

> *Another problem is that I might be told the bill is 7,000 shillings [approximately US$ 70.00] and pay 7,000 shillings, but they write the bill as 3,000 shillings.*
>
> **Female Focus Group Discussion Participant, Ravine Ward, Baringo County**

> *Maybe they have given out medicine and they want you to pay maybe 50 shillings [approximately US$ 0.50] and sometimes this medicine has been given for free. Maybe they have given out nets, they want maybe 100 shillings [approximately US$ 1.00] and the net has been written 'Not for Sale'. Now that defeats us. The government is giving out but the hands that they go through is sometimes bad.*
>
> **In-Depth Interview Participant, Central Kamagambo Ward, Migori County**

> *You find that private hospitals have medicine. Why do government hospitals not have medicine? You ask yourself where the private hospitals get the medicine from. It is possible that doctors are given, and they go and sell to the private hospitals?*
>
> **Male Focus Group Discussion Participant, Eburu Mbaruk Ward, Nakuru County**

Study participants reported that there did not appear to be procedures in place to prevent health facility staff from overcharging. A participant from Kisumu County, for example, articulated the need for checks and balances with financial accounting.

> *Because the government brings things to be used for free but the doctors, it is like they agree and they speak the same language, so if there is a way the government can make the hospitals be strict in that if they see you paying money for what you are not supposed to, they should see what to do. I do not know what they can do, but they should be strict on those people who make people to pay.*
>
> **Female Focus Group Discussion Participant, Kisumu West Ward, Kisumu County**

In some cases the line between corruption and inefficiency appeared uncertain. As a participant in Migori County suggested, when medications are unavailable at a health facility and clients are referred to a chemist to purchase medicine, it might be an example of corruption.

> *The most thing that is a barrier is corruption. In the hospitals, there are medicines that should be there. But, when you go there you find there are no medicines. Pregnant women go to seek treatment and they are only given panadol. They are sent to the chemistry to buy medicine. That discourages most of the women from going to the hospital. If there is no corruption women will not go to the TBA.*
>
> **Focus Group Discussion Participant, South Kamagambo Ward, Migori County**

Data from the study indicate that women generally expect maternity services to be free at public health facilities. However, numerous participants reported instances where maternity services included charges. Participants from Migori and Nakuru Counties, for example, expressed frustration regarding fees that they incurred for services intended to be free.

The government says that maternity is free and at times, you get referred to a given hospital. When you are operated on then you pay for the services. But when it is by the normal way then it is usually free. I think that both of them should be free because they are all processes of giving birth.

Focus Group Discussion Participant, Central Kamagambo Ward, Migori County

When you go to maternity, there are injections they give. They should not sell those injections. They should be free so that when we say maternity is free, everything is free. We should not be asked for anything.

Female Focus Group Discussion Participant, Keringet Ward, Nakuru County

The expectation of free maternity services was common across all six counties; however, the capacity to provide such services varied from county to county. Participants from Samburu and Turkana Counties, for example, noted that health facilities in many cases lack maternity wards; thus, the promise of free maternity services is essentially hollow.

INT *What about challenges that are in this area?*

PAR *We do not have a maternity. We have to go to a further distance to get the service. We have to wait for vehicles owned by kikuyus and we wake them very late at night, therefore we would like our own maternity so that we can help mothers deliver here with our nurses and I included.*

INT *What is the challenge with vehicles?*

PAR *They are not available here. Just imagine someone living on that mountain that is very far. Our young men only own motorbikes and they will not be good for a woman in labor. When they are in labor we call for those who take long to deliver and for those who deliver faster we help them.*

INT2 *When you make calls, do the vehicles come fast?*

PAR *Yes, they come very fast but will ask you for a lot of money, which is 5,000 shillings [approximately US$ 50.00] so it is also expensive. Yesterday I was asked where is your maternity and I told them it is not built, what would I told them and it is not built? This is a big challenge because when they are in labor we follow them around.*

Key Informant Interview Participant, Maralal Ward, Samburu County

Here at our hospital, there is no water. There are no lights. When a woman delivers at night and faints, they cannot see because of the darkness. There is no fence around our hospital. Here at our hospital, there is no place for women to deliver or even if they come and deliver here, there is nothing that could be used to clean up this place. The blood will just remain on the floor.

In-Depth Interview Participant, Lopei Kataruk Ward, Turkana County

Across the six counties, many participants reported that inability to pay would likely result in being denied services. In some cases, the participants indicated that denial of services based on inability to pay made them feel discriminated against, and that the discrimination would continue in the future whether or not they were able to pay for services.

Participants also often stated that payments tend to be non-negotiable and that if one was unsatisfied with the services, there was no recourse. Further, the participants reported that they generally are not able to cover unexpected and hidden costs. The risk of facing such costs is a deterrent to seeking services at a health facility, as described by a participant from Baringo County.

Linda Mama [a public funded health scheme] should be comprehensive to include ANC. That is the main reason why you find many [women] have gone to visits. But you find the ANC profile is not done and it is because of the financial constraint. When they [women] come here in the maternity since we admitted patients and the maternity is free of charge, so it should be comprehensive. Scanning is also charged. We now recommend first trimester, second trimester, and third trimester so you find it is charged. I do not know why Linda Mama is not comprehensive. They [women] need to feel like they are going to the hospital and will not be charged. You will find others will not go to those visits because they are like I will be told to go to the lab and I will have to pay.

Key Informant Interview Participant, Lembus Perkerra Ward, Baringo County

Data from the study indicate that seeking health services at health facilities yields both positive and negative experiences (see Table 9). In some cases, negative experience is the result of a structural or systemic problem, such as corruption, low capacity, or hidden costs. When faced with these types of problems, individuals have limited power to fix them. If the problems continue over time, negative views of health facilities can become more deeply entrenched.

5.5 Conclusion

Each of the research questions for this study is oriented toward expanding understanding of women's actions, choices, and degree of agency in relation to place of delivery. The focus in this chapter has been to take a step back from the single point in time a woman delivers a baby and examine more broadly how women experience and navigate health services and health facilities. With this focus, the aim has been to explore the details and nuances surrounding perceptions and beliefs about health services and health facilities. Data from the study suggest that, generally, women hold favorable views about the option of seeking health services at health facilities, yet these favorable views coexist with a certain selectiveness around traditional approaches and casting health strictly in biomedical terms. The participants in the study expressed considerable awareness that the role of a health facility is changing, and these changes move health services and health facilities further toward biomedical approaches and both reinforce and introduce challenges due to corruption, low capacity, and hidden costs.

Chapter 6 begins with a focus on the role of SBAs and TBAs to continue the examination of the ways biomedical and traditional approaches coexist and then discusses some of the ways that food-related practices as well as broader cultural and traditional practices create tensions surrounding choices and actions in relation to place of delivery. Chapter 6 examines the six counties collectively.

6 PRACTICES, BELIEFS, AND TENSIONS DURING PREGNANCY

Kenya's tribal diversity results in a range of cultural and religious practices in relation to maternal and child health. This chapter explores some of these beliefs and practices—specifically the ways in which SBAs and TBAs coexist within the study communities and the complementary as well as divergent roles they play. The chapter then examines food-related beliefs and practices, including dietary diversity, beliefs about food, and the significance of food taboos and herbs. Next, it examines shifts in social practice and the role of family and social support for women during pregnancy and after delivery. The chapter concludes with a discussion about religious, tribal, and cultural beliefs and how they affect women during pregnancy, delivery, and postpartum.

6.1 The Coexistence of SBAs and TBAs

Comparison of biomedical and traditional medicine was common among the participants. They noted the differences both during pregnancy and delivery in seeking health care from SBAs and TBAs or older women. However, the participants did not view these two types of providers as mutually exclusive, but rather as serving different purposes. In fact, several of the TBAs interviewed noted that they often refer women to health facilities. Although most participants expressed willingness to seek health care from both SBAs and TBAs, some participants indicated a preference for one or the other.

As noted in Chapter 5, data from the study suggest that although the use of traditional forms of care are prevalent, many women also use and have favorable views about health facilities and SBAs. Several participants spoke of being tired of the challenges associated with home deliveries. Participants also discussed receiving support and encouragement from family to deliver at a health facility as a means to alleviate these challenges. A participant from Baringo County discussed why health facility delivery was preferred. Later in the interview, the same woman mentioned how family and friends supported the decision to deliver with an SBA.

Now, going to the hospital is good, because when you are at home, you cannot get all those services. You cannot test yourself. You see if you deliver a baby who has HIV, you know nowadays even if you have HIV there is a way you are helped you can deliver a baby who does not have that disease and you can bring it up and it will be okay. You see going to the hospital is good because you will be told such things. If you do not have blood you will be told the food that you need to eat so that it adds you blood so that during the date of delivery you will not be in danger.

In-Depth Interview Participant, Ravine Ward, Baringo County

INT	*And is there anyone who helped you to make that decision? Did anyone help you decide that it is important to go to the hospital when you were pregnant?*
PAR	*It is friends, mother, nowadays mothers have become clever it is not like mothers in the past.*
INT	*Is there anyone else?*
PAR	*Even my husband insists nowadays that you go.*
INT	*And their reasons for insisting, still match your reasons that you have told me above or they also have their reasons?*
PAR	*Maybe they are seeing how other people get in problems or are suffering when they deliver at home, so they do not want to experience such a thing in his family if it is the husband.*

In-Depth Interview Participant, Ravine Ward, Baringo County

Most participants noted the ability of SBAs to deal with complicated cases as a primary reason for going to a health facility. A participant from Migori County described this type of reasoning.

I think the reason women deliver at the hospital, even if your delivery becomes complicated they will find a way of helping you until you deliver even it means being operated on. But, for the TBA if delivery becomes complicated she cannot operate on you and stitch you up. Now the hospital is good. They will operate on you and remove the baby. They can help you and your baby. You might go to the TBA and end up dying together with your baby because there could be complications that are beyond the TBA.

Female Focus Group Discussion Participant, Central Kamagambo Ward, Migori County

In addition to providing medical relief and being able to handle complicated cases, health facilities provide women with a space where they can opt out of restrictive traditional practices. Participants from Samburu and Turkana Counties discussed the restrictions around food after delivery as a reason some women favor SBAs and health facility delivery.

When you deliver at home your womb has not be cleansed so you have blood clots. It is believed when you eat food your stomach will bloat. In the hospital they wash your uterus and receive injection and you are able to eat any food.

Female Focus Group Discussion Participant, Loosuk Ward, Samburu County

Let me tell you about the badness of home delivery, in some clans, if you give birth during the dry season where there is no milk, you will have to stay that way until they find milk even if the baby's cord comes off even if it is after two weeks. No taking a bath or eating. You will be like some stone sitting.

Female Focus Group Discussion Participant, Turkwel Ward, Turkana County

In cases where women preferred traditional care, participants viewed TBAs as having a level of knowledge or understanding better than SBAs. These participants also valued the traditional ways birthing took place and the ways TBAs were aware of and able to cater to cultural beliefs and preferences. A participant from Turkana County described some cultural practices that dissuade some women from delivery with an SBA.

In our tradition, we give birth while on our knees but here in the hospital you have to give birth while lying on your back. Some women feel like they cannot do it. They had to build a manyatta at the hospital so that they can feel comfortable. Also, being helped by a male doctor to give birth is seen as immoral because they would have seen you naked.

In-Depth Interview Participants, Turkwel Ward, Turkana County

TBAs are well-respected members of the community and are able to call upon family members or others in the community to provide additional support to women during pregnancy and delivery. As described by a participant from Kisumu County, because of their status TBAs can provide extra support that is not available at health facilities.

The reason as to why I like delivering at the TBA…I normally deliver big babies and I normally do not have the strength to push the baby. The TBA might call someone from my home to give me support so that I can push the baby to come out. In the hospital if I go I will struggle alone.

Female Focus Group Discussion Participant, North West Kisumu Ward, Kisumu County

The participants often mentioned massages as something TBAs or older women are better able to do to ensure the baby is in the correct position and to limit pregnancy-related complications. Participants from Kisumu and Turkana Counties described the benefits of the massages given by TBAs.

There are those good TBA that say that they massage you using traditional herbs so that when it reaches your time for delivery you will not have complications.

Female Focus Group Discussion Participant, North West Kisumu Ward, Kisumu County

When you feel that you are not well, you look for a woman who will massage you and make the blood come together. We have one who knows how to do it well here and they say that a disease called moruariwon is what affects most women when they are pregnant. This can be treated by being massaged.

Female Focus Group Discussion Participant, Lopei Kataruk Ward, Turkana County

As participants from Turkana County expressed, traditional methods were preferred for the treatment of certain illnesses, specifically those associated with witchcraft or other supernatural causes that biomedical medicine could not cure.

There is witchcraft. Maybe your neighbor or a witch has cast a spell on you, when you go to the hospital they just give you medicines which most of the time do not work. They continue giving you modern medicine and you end up dying. They do not know that some diseases require traditional treatment.

Female Focus Group Discussion Participant, Turkwel Ward, Turkana County

Participants gave reasons for seeking treatment from both TBAs and SBAs, who were both viewed as providing beneficial services to women. A TBA in a key informant interview said that with the increase in the number of facilities and the directive by the Ministry of Health to eliminate home deliveries, TBAs were now referring women to health facilities to deliver. However, women were still coming to TBAs for services like massages, or in cases where it was not possible to assess a health facility.

Nowadays there is a dispensary in the community so they just come for massage to check on the position of the baby. Even if it is at night I just massage them and on reaching in the morning I tell them to go to the hospital because nowadays the Ministry of Health does not allow the traditional birth attendants (TBA) to do deliveries on the pregnant mothers. So, I tell them to go to the hospital because they will be offered medicine after delivery and at my place I don't have any medicine to give the mothers.

Key Informant Interview Participant, Kisumu West Ward, Kisumu County

Data from the study show that across all six counties both SBAs and TBAs play important roles in women's lives. Women are encouraged to deliver at health facilities, and TBAs refer women to SBAs. Participants viewed health facilities as having SBAs who are able to deal with complicated cases and to provide women with a way to opt out of restrictive traditional practices. However, TBAs also provide valuable services. TBAs are supportive of traditional practices and are available if a woman is unable to access a health facility. TBAs also perform services, such as massages, that women view as beneficial for pregnancy and delivery.

6.2 Food-Related Beliefs and Practices

Biomedical and traditional medicine and cultural beliefs and practices place emphasis on the type of food consumed during pregnancy and post-delivery. Health care providers promote dietary diversity and have guidelines on what women should and should not eat during pregnancy and while breastfeeding. Health care providers view a diverse diet as one way to improve women's health, the health of the baby, and ensure that women have adequate nutrients for breastfeeding. Traditionally and culturally in Kenya, food also plays an important role during pregnancy and postpartum; several participants described specific food-related processes, beliefs, restrictions, and taboos. As described by a participant from Samburu County, these restrictions can have negative consequences.

We have a problem with our culture that women are subjected to some difficulties e in terms of nutrition. When they slaughter some animals a woman is not supposed to take some organs which are rich in iron like liver, it is meant for men. They tend to disadvantage women from getting nutrients. Also, they are the ones to take care of the family in terms of fetching water, collecting firewood, preparing their houses, looking after their animals. Women sometimes are subjected to challenges when they are pregnant.

Key Informant Interview Participant, Maralal Ward, Samburu County

Participants from Turkana County echoed similar sentiments, provided several examples of the ways food-related beliefs have negative consequences for women, and questioned the relevance of such practices. They also highlighted how these beliefs are at times contradictory to advice given by SBAs.

INT *What about food? Was there food that a woman was meant to eat or not eat during pregnancy?*

PAR3 *There is segregation in our culture because men eat the best parts of the animal. They eat the head, chest, liver. Women eat the other bad parts like intestines, which she has to share with the children again. Soup is the only good thing a woman takes.*

PAR9 *They do this because they say that if you eat all these good parts of the animal like the fatty meat the baby will grow big and you will not be able to deliver. You are not meant to use animal's fat and milk either. You should not use much.*

INT *Another thing? PAR7?*

PAR7 *Why do they say that we should eat these foods in the hospital? They say that we should eat proteins, kales, beans and fish? And yet they do not allow women to eat these foods traditionally? That animal's fat is what makes heartburn go down and even makes your food softer. We should go back and ask these men the meaning of that.*

Female Focus Group Discussion Participants, Lopei Kataruk Ward, Turkana County

Participants discussed several post-delivery practices around food. For example, women are given a mixture of animal blood and fermented milk and butter (*saroi)*, which is thought to be nutritious for the mother and to increase the production of milk. The participants also reported slaughtering a goat and using it to make soup that helps build up the blood lost during delivery and facilitates breastfeeding. Participants also mentioned other beneficial cultural practices performed after a woman gives birth. A participant from Turkana County described several food-related cultural practices.

INT *Are there traditions that are performed when a woman gives birth at home?*
PAR *Yes, there are many traditions and rituals that are performed. They are rituals such as Anapet where people go and gather wild fruits. They slaughter a big goat and the house where the woman and the baby are staying is covered well. They light a fire and begin other rituals.*
INT *What are these rituals?*
PAR *We eat Edea [meal that women eats during delivery] and do Lokoit [break the bone of the goat that has been slaughtered]. Some clans cook plain maize where the older women eat the plain maize and younger women cook the slaughtered goat. They wash the baby and the mother too.*
INT *Are there rituals that are harmful to the health of the mother and the child?*
PAR *No. The baby is well taken care of and other women help the mother in hygiene and in performing other household chores until she feels better.*

Key Informant Interview Participant, Lopei Kataruk Ward, Turkana County

In addition to discussing beneficial practices, participants also discussed taboos and beliefs about what women can or cannot eat during pregnancy and after delivery. Most of the discussions were about the negative impact of consuming a particular type of food. For example, participants mentioned that babies would be born deaf if the mother consumed eggs, and that certain foods would make the baby too large and lead to complications during delivery.

Data from the study indicate that the use of herbs is common during pregnancy, delivery, and postpartum treatments. As described by a participant from Samburu County, herbs served multiple purposes including healing, countering witchcraft or other bad omens, and cleansing.

INT *Are they [herbs] still being given till now?*
PAR *Yes, they are being given even now, when we notice that the blood clot has not come out we give lolsesyai [part of the santalaceae family of flowering plants] and it comes out. They are also given lngeriyoi [African olive, often infused in milk] if they find it hard to remove the placenta.*
INT *It is the one that removes that placenta? Is it given like that?*
PAR *It is mixed with oil.*
INT *How is this lngeriyoi used?*
PAR *We cut the herbs of the tree, it is boiled and one tablespoon of butter is added to it, if the placenta has not come.*

Key Informant Interview Participant, Maralal Ward, Samburu County

Although the participants discussed herbs as commonly used and viewed as beneficial, some participants noted that herbs could also be harmful. A participant from Migori County described how her husband discouraged her from using herbs.

> *Because when I am sick he will not advise me to go get herbs, you are going to look for herbs and you do not know what you are treating. Now I have to go to the hospital.*
>
> **In-Depth Interview Participant, Central Kamagambo Ward, Migori County**

Food plays an important role in women's journey from pregnancy to post-delivery. Participants discussed the importance of food consumption and the advice given from both the biomedical and traditional perspectives. At times, the biomedical advice contradicted the traditional advice, and participants mentioned negative aspects of food-related traditional practices. As noted earlier in this chapter, participants viewed health facility delivery as a way to avoid perceived negative traditional post-delivery practices associated with food. Additionally, herbs were also discussed as having both positive and negative uses throughout a woman's pregnancy and post-delivery.

6.3 Shifts in Cultural Practices and Social Support

Although traditional practices and beliefs placed constraints on the types of food that women were able to consume, participants also discussed poverty as a driving factor in access to food and dietary diversity. In addition to poverty, participants underscored how environmental changes have led to a reduction in their livestock. The reduction in livestock has placed further restrictions on certain traditional practices. However, participants made many efforts to uphold certain practices. Some participants in Turkana County noted that once a woman follows a tradition or practice with one child, she should follow it with all of her children or risk introducing problems to the other children. Such sentiments align with the view that if a child was born healthy and the woman used traditional practices, then the practice should continue.

As much as participants discussed cultural practices that continued and were thriving, several participants also discussed shifts or changes in cultural practices. Regarding food-related beliefs, some participants mentioned that although women used to follow practices that prescribed what they could and could not eat, this was no longer the case and women could eat anything they wanted. In addition, older generations are not passing on knowledge on how to implement certain practices. A participant from Baringo County described this shift.

> *In this community there used to be women who used to train women. But, right now, they are not there so you see maybe her husband helps with reducing the work. Other than that, they do not get to know. They work until the end. There used to be older women who would train. They used to help women understand themselves, go for clinic and it comes to the worst, they used to help women deliver. Now, they are now very old, seventy years old, so training now for women is not there.*
>
> **Key Informant Interview Participant, Lembus Perkerra Ward, Baringo County**

Data from the study indicate that women receive support from a range of individuals. Table 10 summarizes perceptions regarding social and family support as reported by in-depth and key informant interview participants.

Table 10 General perceptions regarding social and family support

In-Depth Interviews	% Yes	% No	N	Key Informant Interviews	% Yes	% No	N
In the first few weeks after delivery, was your family supportive?	88.1	11.9	59	In the first few weeks after delivery, do you think women in this community feel that their family is supportive?	91.3	8.7	23
In the first few weeks after delivery, did you ever feel afraid?	35.0	65.0	60	In the first few weeks after delivery, do you think women in this community ever feel afraid?	19.0	81.0	21
Do you think service providers at hospitals offer good advice?	98.3	1.7	58	Do you think women in this community feel that service providers at health care facilities offer good advice?	100	0.0	23
Do you think service providers at hospitals explain things well?	98.3	1.7	59	Do you think women in this community feel that service providers at health care facilities explain things well?	100	0.0	23
Do you think service providers at hospitals treat women with respect during pregnancy and delivery?	76.3	23.7	59	Do you think service providers at hospitals treat women with respect during pregnancy and delivery?	95.7	4.3	23
Do your family members offer good advice regarding your health?	89.7	10.3	58	Do you think women in this community feel that their family members offer good advice regarding their health?	90.9	9.1	22
Do your family members ever make it hard for you to be a good mother?	27.1	72.9	59	Do you think women in this community feel that their family members ever make it hard for them to be a good mother?	50.0	50.0	22

In general, participants reported receiving support during pregnancy and after delivery. As presented in Table 10, 88% of in-depth interview participants said their family was supportive in the first few weeks after delivery, and 91% of key informants thought that women in their communities were supported by their families. In examining responses in relation to place of last delivery, women whose last delivery was in a health facility reported more support (98%) compared with women whose last delivery was at home (79%) (see Appendix 5.4).

Across the six counties, participants noted that the announcement of a pregnancy was joyous. Husbands and mothers-in-law were mentioned as primary sources of support during pregnancy and after delivery. Participants described their role to be of particular importance given that, with some tribes, the woman leaves her natal family to stay with her husband's family. In addition, women received support from other family members, neighbors, older women, TBAs, and CHVs. However, the types of support varied. The participants often described the support received from their husbands in monetary terms, such as providing transport to a health facility or paying for health-related expenses. In contrast, support with household chores came from other female family members or women in their community.

Among in-depth interview participants, 12% reported that their family was not supportive in the first few weeks after delivery, and 9% of key informants said that family members of women in their communities were not supportive (See Table 10). Shifting social dynamics and cultural norms that result in less support for women were also evident in the discussions around social and family support. A participant from Turkana County described this trend.

Before the modern heath care services came, there was help. Women were helped by their families. For example, I have a good relationship with my in-laws. Parents used to love and care for their children. That was before. Nowadays they do not help. It is upon you to carry every burden of that woman. Maybe the mother will come to see her due to sympathy. Why? Because today a boy and a girl meet and get married, they have their own families without the knowledge of the parents. In case of any problem they will say that you go and solve it with the person you decided to marry in secret. Before, a woman used to deliver at her parents' house. You will be staying with your parents too as a shepherd. They will be sending information to you on how your wife is progressing or if the baby died at birth.

Male Focus Group Discussion Participant, Turkwel Ward, Turkana Country

Although participants described pregnancy as something positive, they also discussed it as something ordinary that did not warrant extra care or support. Examples of reasons for limited support included the physical absence of husbands, husbands having responsibilities to other wives, disputes over the pregnancy, and the perception that they belonged to a tribe that was not supportive of women.

Another trend that participants noted was the increase in female-headed households or cases in which women had children out of wedlock. Women in these categories were often described as facing additional challenges and lacking support during pregnancy, delivery, and the postpartum period from husbands and their extended families, specifically their mothers-in-law. Participants from Turkana County described this shifting dynamic.

PAR2	*What has introduced this is having single families, whereby young girls give birth before marriage; yes they do get help in the first few days then they are left to work on their own. Who then help them for so long? They just rest for a short time then they resume back to their work.*
PAR3	*These girls who get pregnant before marriage have no one to look after them.*
PAR7	*They are so many nowadays.*
PAR4	*If it is your sister, you feed her for like a month, then from there she goes back to her manual jobs because she does not have a husband to look after her.*
INT	*They do not have a specific time when they rest?*
PAR8	*There are those who have a resting period, that is if they have a support system.*
PAR2	*Those who rest for long are those with husbands because her husband will work and give her time to gain her strength. For those who do not have their husbands they will have no choice but to return early.*

Male Focus Group Discussion Participants, Loosuk Ward, Samburu County

Participants discussed how changes in sociocultural expectations and norms are affecting women's pregnancy, delivery, and post-pregnancy expectations. Although support during pregnancy is expected, changing social dynamics such as an increase in female-headed households or distance from family limit the amount of support that women receive during and after their pregnancy. Changing environments also limit access to resources needed for traditional practices related to pregnancy and delivery. Although some sociocultural practices pose challenges to traditional delivery-related practices, participants also discussed how experiences of successful traditional practices linked to home delivery encourage the continuation of these practices.

6.4 Religious, Tribal, and Cultural Beliefs

Kenya is ethnically, culturally, and religiously diverse, which is reflected across the six counties studied. Participants commonly discussed religious, tribal, and cultural expectations as influences on decisions made during pregnancy and after delivery. Participants noted some of these cultural differences when discussing experiences during pregnancy, delivery, and postpartum. However, these descriptions were often of "other" groups or tribes. Specifically, participants discussed how particular beliefs by "other" groups influenced where women delivered, as reflected by participants from Baringo County.

INT	*Okay, are there any cultural beliefs and practices in Kalenjin that may influence the choice women make about where to deliver?*
PAR10	*If we have said it is the hospital, then it is the hospital.*
INT	*Maybe it is said us in Kalenjin it is home because of this and this and such things.*
PARs	*No, no. we no longer have such things.*
PAR10	*Those ended.*
PAR7	*We do not have in this area.*
PAR11	*Though sometimes they are there, they emerge from Baringo county but it is not here.*
PAR9	*It is lower part of Baringo, it does not get here.*
INT	*So, what is it that is there?*
PAR6	*I think they have their own culture that is different.*
PAR11	*Even immunization, like the polio they do not accept.*
PAR9	*But it is not that they are things related to Kalenjin culture?*
INT	*The Pokots have it but we do not have.*
PARs	*We do not have.*
PAR9	*The problem with many people is they have not understood that Baringo is big, and Baringo is different, the lower part of Baringo and upper part of Baringo. They are very different.*

Female Focus Group Discussion Participants, Lembus Perkerra Ward, Baringo County

Participants also used religion to justify the increase in seeking health services at facilities and limiting traditional or cultural practices. A participant from Nakuru County described the role that religion plays in shifting cultural beliefs.

We do not see a lot of cultural beliefs nowadays because most people have known God. Salvation has changed people; they have ceased the cultural beliefs that people used to follow. It seems that most people at this time, the person who does not understand things at the hospital is that person who does not know God. But, if they know God everyone depends on going to the hospital. And there are no cultural beliefs.

Female Focus Group Discussion Participant, Eburu Mbaruk Ward, Nakuru County

Participants discussed the role of religion in access to health facilities. In particular, many participants noted that some religious denominations discourage seeking care at a health facility. The procedures mentioned that are discouraged include receiving blood transfusions, IVs or anything foreign in one's body, and immunizations. A key informant participant from Baringo County gave an example.

The Wakorino, if you take their history, you will find it is home delivery. And she has maybe ten children. If you follow it up you will find out that she thinks if she loses a lot of blood I can be transfused. Even the IV fluids, she can be given fluids that maybe she has seen, some religion do not want anything from any person. Do you know hospital visits, when she visits her friend she will see a transfusion and she will be like, I am not going to the hospital because I will be IV transfusion.

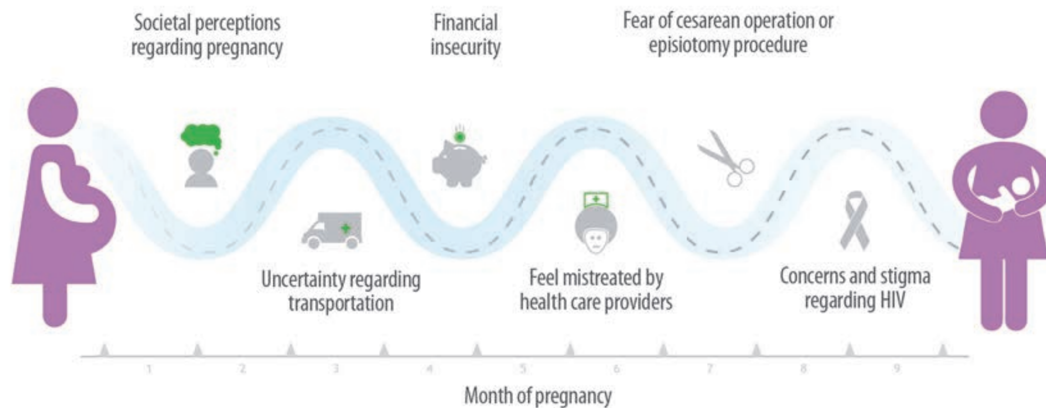
Key Informant Interview Participant, Lembus Perkerra Ward, Baringo County

In addition to religious beliefs that discouraged use of biomedical interventions, participants also mentioned traditional or cultural practices that conflicted with biomedical practices. These came into play at any time from pregnancy through the postpartum period. Participants described several traditional and cultural beliefs concerning behavior during pregnancy, such as not being able to attend funerals, avoiding sex with your husband, and not moving into a new home. They gave reasons for following these beliefs. For example, having sex with one's husband was thought to make the baby dirty, attending a funeral or viewing a dead body would lead to a miscarriage, and interacting with certain individuals would cause harm to the mother or unborn baby. There were several discussions among the participants about practices during delivery. For example, some participants stated that deliveries could not take place at the mother-in-law's house or in the presence of men because they should not see the woman naked.

6.5 Conclusion

This chapter discussed how SBAs and TBAs, although serving different purposes, coexist within the same communities. TBAs are available when SBAs are not accessible, are knowledgeable about cultural beliefs and practices, and provide women with beneficial services throughout their pregnancy. In addition, beliefs and practices related to food play an important role throughout women's pregnancy and during the postpartum period. Participants frequently discussed traditional or cultural restrictions and expectations concerning what they should and should not eat during and after pregnancy. Participants viewed health facility delivery as one of the ways to avoid some of the restrictive cultural and traditional expectations. Further, although many women receive social support during pregnancy, changing social cultural norms and environmental conditions impose limitations to social support and certain traditional and cultural practices. Participants also discussed religious, cultural, and tribal beliefs as both promoting and dissuading health facility delivery.

7 EXPERIENCES, FEELINGS, AND DECISIONS DURING PREGNANCY



This chapter considers women's experiences during their journey from pregnancy to delivery. The analysis details how women's perceptions and decisions are often shaped by how they feel. These feelings include fear; low self-confidence; and being judged, shamed, and stigmatized by current social status, previous experiences, and HIV status. The role of TBAs in shaping women's pregnancy journeys is also explored, particularly in terms of the interpersonal connections between pregnant women and TBAs. The chapter examines how health workers' poor treatment of women can deter them from delivering in health facilities, and how women's feelings and their own understanding of situations influence their decisions on where to seek services during pregnancy and delivery.

7.1 Women's Intrinsic Fears and Insecurities

Across the six counties, the data include numerous instances of participants reflecting on how they feel and perceive themselves during pregnancy. Some participants described feeling ashamed of themselves, not liking how they looked when pregnant, and being uncomfortable in the same health facility with young girls. In addition, the participants reported feeling financially insecure, including lacking resources to cover the cost of traveling to a health facility. For example, a participant from Nakuru County described feeling 'contempt' for herself and feeling financially insecure during her pregnancy.

PAR: *I can say I made those decisions because of contempt for myself. And I saw I had problems and I could not go call and ask for help somewhere. I saw that is one problem. I felt that let me just stay at my place.*
INT: *You have told me it is contempt and you saw you had problems. What problems were these?*
PAR: *You are with no one in the homestead. It is just you and your kids. Now, there is no child you can tell to give you money or tell them that you are pregnant...*
INT: *It was a financial problem?*
PAR: *The problem was just of.... The problem, the biggest problem was financial and contempt.*

In-Depth Interview Participant, Eburu Mbaruk Ward, Nakuru County

For some participants, fear in relation to unplanned pregnancies was a cause for concern. Feelings of fear appeared heightened for unmarried women, women living with their parents, and women in school. Some participants recounted fears around the operating room and surgical procedures, notably an

episiotomy and a caesarean section, as well as fear of dying during labor. Participants from Samburu County made statements regarding fears of this type.

PAR: *I was afraid because I got pregnant while I was at my parents' home.*
INT: *What did you fear?*
PAR: *I was afraid because I was about to finish school and I was pregnant.*

In-Depth Interview Participant, Maralal Ward, Samburu County

PAR 3: *We fear this a lot, you fear that when you go to the hospital you will be operated so that is what we fear most, operation.*
PAR 7: *You know the thing we fear in the hospital they have that which when you are still a new mother, when you are taken to the hospital they insert scissors to cut you when you are still a new mom. Therefore, there are many women who have delivered at home and others have told them don't go to the hospital because they will cut you and then stitch back, or don't go to the hospital because they will cut your stomach and you have never been cut in this other child of yours. So, that is what I can say affects women a lot and that is why many don't go to the hospitals.*

Female Focus Group Discussion Participants, Maralal Ward, Samburu County

In addition, participants indicated awareness of the potential risks associated with excessive bleeding and a TBA's lack of skills or equipment in handling labor complications or premature deliveries. The participants further expressed their fears in relation to the risk of infection from delivery at home given that TBAs often do not use gloves. Participants from Nakuru and Migori Counties talked about these fears.

Because nowadays you cannot deliver at home, maybe you can get other problems. Yes, you can get a baby well but things like bleeding, maybe retained placenta, I think that is a problem to deliver at home. Maybe they have helped you deliver at home but those other things like bleeding they will not be able to treat. It is better to go to the hospital because those are the ones who know what to do.

In-Depth Interview Participant, Keringet Ward, Nakuru County

PAR5: *In addition, the disadvantage of delivering at home. The TBA helps many women to deliver. Each woman as they come, she helps them to deliver and she does not use any gloves in helping all these women. With that, it is very easy for her to infect you with any disease.*
PAR9: *That is what I wanted to say. They do not use clean gloves, you will find that the gloves that she had used on someone else she will rinse and again use them on another woman. Maybe earlier on she had helped a woman who is HIV positive then again, the same gloves she uses them on someone who is clean. With that, it is very easy to infect someone. Maybe the TBA herself is HIV positive and she helps you to deliver with her bare hands and you are not infected, that is very bad.*

Focus Group Discussion Participants, South Kamagambo Ward, Migori County

The data indicate uncertainty about the impact of traditional herbs for women and babies, as well as unknown impacts of mixing medicines and herbs, as exemplified by a participant from Baringo County.

PAR7: I have small opinion, we have one problem. You might go and use medicine from the hospital and mix with traditional medicine, can they really work together?
INT2: In your opinion, how do you see it?
PAR7: There you might find that someone is using traditional herbs and then she gets another advice to go the hospital yet those medicines do not go together. Now my advice is that people should learn, use one medicine. If it is from the hospital, use the one from the hospital. If it is traditional, use the one from traditional. Mostly you find that people die because of mixing those two types of medicine. Because you can mix traditional herbs and medicine from the doctor because you will find that maybe the traditional one has more strength than the one from the hospital so it becomes a poison to you and it finishes you.

Male Focus Group Discussion Participants, Ravine Ward, Baringo County

The participants described their fears and insecurities as emanating from feelings of being embarrassed about how they look while pregnant and how their community members perceive them. The data suggest that these fears and insecurities most commonly surface when pregnancy occurs while in school or before marriage, or in instances when women lack the financial resources needed to cover pregnancy-related costs. Additional fears that the participants mentioned included fear about the potential need for surgery during a health facility delivery, possible maternal death, poor infection control, and the inability of TBAs to deal with complicated labor. The data indicate that fears and insecurities play a role in the decisions women make in relation to seeking health care.

7.2 Negative Attitudes and Poor Treatment from Health Facility Staff

Across the six counties, the participants told of experiences of feeling disregarded and treated poorly by health care providers in facilities. In particular, many participants described the poor treatment in terms of verbal abuse and physical mishandling. Examples of verbal abuse included feeling admonished for coming late in their pregnancy for ANC visits, impatience on the part of health providers when their instructions were not understood, and being ignored during rounds. The participants described situations when women who had previously delivered at home were scolded for that decision, and that these women were often made to wait in queue as a sort of punishment for not choosing to deliver in the facility. In instances where women did not yet have their ANC card, participants often indicated that health care providers would cast judgment, and again queues became a sort of punishment. Participants from Migori and Baringo Counties described specific types of verbal abuse.

Maybe I have gone to the clinic late, my clinic time had passed. Maybe I was taking the child to the clinic or I was taking myself, I am late, I will be chased away. You know if you chase me away with my baby maybe I boarded a motorcycle, I paid transport. I will not agree with you, we will have conflict.

Key Informant Interview Participant, Central Kamagambo Ward, Migori County

Maybe when someone does not have a card. If you did not have that you might have a problem because when you have that card they will not disturb you even a little bit.

In-Depth Interview Participant, Keringet Ward, Baringo County

Several participants reported instances where ethnicity and tribal profiling shaped the ways health care providers treated women in health facilities. Tribemates were given preferential treatment over outsiders in relation to, for example, being able to jump ahead in queues or amount of time and levels of patience in posing questions to health care providers. A participant from Migori County described an instance of tribal profiling.

There are those doctors that are arrogant. We as women, we know the doctors and the nurses that talk to us in a polite way. There are those nurses that are very arrogant. For instance, she had written on the clinic card a clinic visit date, maybe you skipped that date and come to the clinic a different date. She will not even ask the reason why you did not come to the clinic. Maybe you were sick and did not have money to come to the clinic. She will shout to the woman why she did not come to the clinic.

There is a case I witnessed in the hospital while I was there. The woman I took to the hospital had a small baby and we were in the queue at the bench. This woman skipped the day she was to bring the baby in the clinic and came another different day. The nurse started shouting at that woman telling her, "you mean in Kisii there are no hospitals, you come all the way to bring the child in Luo land." I saw tears rolling down the cheeks of this woman. Then the nurse again says, "in fact it is 11.00 am go back and come another day." She was not attended to.

The following day this woman came again and found me in the hospital again. That day when she came she found the same nurse that harassed her the previous day. This woman was crying. Lucky enough there was another guy that comes from her area so she called him. After talking to this guy, he went and told the nurse in charge, the nurse in charge is the one who came to talk to this nurse; that is when this woman got help. It depends, the patients will choose the person they feel will treat them well.

Focus Group Discussion Participant, South Kamagambo Ward, Migori County

In addition to verbal abuse, the participants reported that health care providers sometimes handled them roughly during physical examinations. Most participants appeared to feel that female health providers, particularly nurses, were more inclined toward verbal and possible physical abuse. The participants tended to indicate that abuse and mistreatment were more common in the public health facilities compared with private and missionary health facilities. In one instance, participants from Samburu County expressed concern about the physically rough treatment of pregnant women during delivery.

INT: *In the past because it seems there is something that the doctors did with that first baby that you went so that you did not go deliver this other in the hospital?*
PAR4: *There is nothing.*
INT: *Is it not the injection?*
PAR4: *It is not, I even went for all clinics.*
PAR5: *When you are fearful they beat you.*
INT: *Are they still beating?*
PAR5: *Yes, when you are crying they will add it up by beating you.*

Female Focus Group Discussion Participants, Maralal Ward, Samburu County

TBAs tended to be regarded much differently in comparison with health care providers. Most participants spoke favorably about TBAs and in particular valued the massages from TBAs, which they described as comforting and important in determining the position of the baby. In contrast, many participants reported that nurses offered very little comfort during delivery. A participant from Kisumu County provides an example of the views about TBAs compared with nurses.

When we go to deliver at the TBA she is very kind and pampers us. But, in the hospital the person who should be helping you is busy scrolling the phone chatting on the Facebook. While I am in labor and when she hears me screaming and shouting in pain she says she is not the one who sent me to conceive. They end up saying that when I was enjoying she was not with me so I should carry my own cross.

In-Depth Interview Participant, North West Kisumu Ward, Kisumu County

Participants made strong recommendations for the government to train health care providers on how to communicate with and handle patients, as noted by a participant from Kisumu County.

> *The Government of Kenya should employ more doctors and nurses. The doctors and nurses should also be taught to handle patients with care because there are some health care providers that normally shout at the patients instead of talking to the patients in a polite way.*
> **Key Informant Interview Participant, Kisumu West Ward, Kisumu County**

In each of the six counties, the participants noted their desire for respectful maternal care. Many reported that poor management and abuse made them hesitant to seek health services in health facilities. Verbal abuse and rough handling during ANC visits and delivery were reported to be most prevalent in public health facilities and common among female health care workers. This abusive treatment was in stark contrast to the comforting and personalized care women reported to receive from TBAs. In addition to poor attitudes among providers in health facilities, there were also reports of preferential treatment of patients based on ethnicity, which also influenced where women chose to seek health care.

7.3 Social Norms and Perceived Stigma Regarding Pregnancy and Delivery

The data indicate that social norms and the outlook of community members influence women's feelings during pregnancy and delivery. Across most counties, the participants described poor social norms in their communities in terms of how women are perceived, and even judged, by community members. Examples included being shamed for unplanned pregnancy, pregnancy at a perceived advanced age, and not spacing pregnancies adequately. A participant from Migori County described these norms and their impacts.

> *INT2: And in the community, what do they go through when they pregnant? Leave alone sickness, you have mentioned sickness and pain, what else do they go through? Is there anything that happens to them in the community?*
> *PAR: Some feel shame, some are afraid. You know she is pregnant.*
> *PAR: Maybe you are pregnant and you are old. You are pregnant and your daughter-in-law is also pregnant, now you can feel shame and you are shy. She cannot sit where people are. Maybe you are supposed to attend some meetings, now you cannot attend those meetings.*
> *INT2: Because they fear, they are embarrassed?*
> *PAR: Yes embarrassed.*
> *INT2: Why are they embarrassed?*
> *PAR: Maybe you are a woman who is well known in this area, "So and so gave birth last year, she is pregnant again ai!" Now you have shame.*
>
> **Key Informant Interview Participant, Central Kamagambo Ward, Migori County**

Many participants reported feeling stigmatized for not having sons. Male participants often acknowledged that they would not stay with women who were not bearing them sons. A statement made by a participant from Baringo County exemplifies the male preference for sons.

> *It is something that is there, if I want, in fact I have girls, so if I want a boy, I tell her this time round I want a boy. If it is not a boy just go to your home.*
> **Male Focus Group Discussion Participant, Ravine Ward, Baringo County**

The data suggest that support for pregnant women from their male partners is not automatic, and sometimes appeared obligatory. In particular, some participants reported that male partners are often uninterested in being involved in women's specific needs during pregnancy, such as decision-making, going for ANC, offering emotional support, and caring for other children. In several instances, the participants described sometimes 'feeling alone' during their pregnancy. Participants from Nakuru and Migori Counties described the challenges for women who feel they cannot depend on unconditional support from their partners.

> *INT2:* *How much influence do family members have on decisions women make about health care?*
> *PAR:* *Most people we live with are not very responsible towards that. You can find someone is sick and they will give you money to go and seek treatment. Now it is your responsibility to see where you will get the health care. They do not follow up if you went to the hospital and what it is that was diagnosed. They just give you money, "Are you sick? Go to the hospital." Now if the money is not enough for private hospital, you opt to go and buy drugs.*
>
> **Focus Group Discussion, Central Kamagambo Ward, Migori County**

> *There is another small one who has not learned how to even walk properly now, and you know I do a lot of work but my husband did not even help me.*
>
> **In-Depth Interview Participant, Keringet Ward, Nakuru County**

Linked to the poor social norms reported above was the issue of HIV stigma; participants described how community members treated HIV-positive women differently and often negatively. They also reported that stigmatizing attitudes among health care providers deterred women from delivering in health facilities. Participants gave examples of how in some health facilities HIV-positive women were often isolated from HIV-negative women. A participant from Kisumu County described this negative treatment.

> *PAR5:* *Some people fear to be tested for HIV because when they go to the clinic they must be tested.*
> *PAR2:* *Some women feel that when they go to the hospital there are those nurses who are very harsh to the patients. When you go to the clinic at the fourth month they will start shouting at you asking you where you have been the rest of the months, why you haven't gone for the clinic. When you think of being shouted at you decide to just sit back at home and relax.*
> *PAR1:* *Most women fear going to the clinic because of being tested. Someone who has not known their status is afraid of being tested because she sees that she will be tested and might turn out to have it and that will force her to start taking ARVs.*
> *INT:* *How do you call that thing that you fear to mention?*
> *PAR1:* *HIV and AIDS.*
> *INT:* *What is now swallowing HIV medicines?*
> *PAR7:* *Swallowing the ARVs.*
>
> **Female Focus Group Discussion Participants, Kisumu West Ward, Kisumu County**

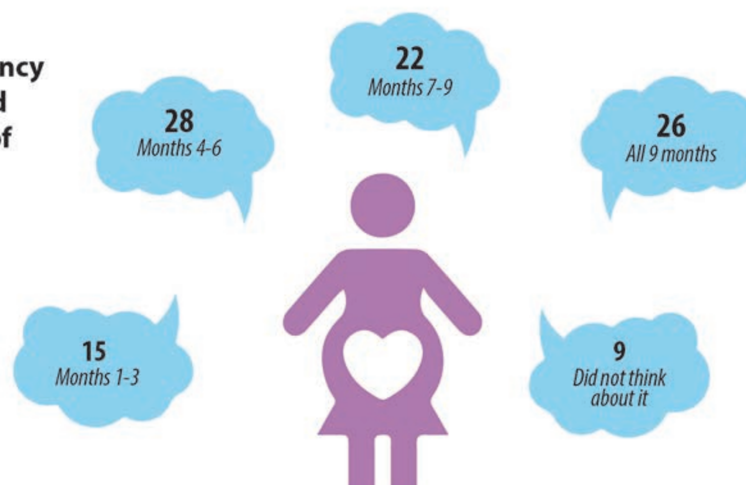
As presented in Chapter 6, across the six counties a range of cultural beliefs and practices shape health-seeking practices. Chapter 7 has discussed women's feelings throughout their pregnancy, and how community perceptions and practices often negatively influence how pregnant women see themselves and the decisions they make during pregnancy. These include stigmatizing women who are HIV-positive, and holding poor attitudes toward women with closely spaced children, women with unplanned pregnancies, and women who give birth at an advanced age. Consequently, participants often reported feeling alone during pregnancy, which heightened women's feelings of insecurity and decision-making about seeking care.

7.4 Conclusion

Individual beliefs and experiences are key to how women make and carry out decisions regarding their pregnancies and delivery. Participants described their source of insecurities during pregnancy, perceived risks, and fears regarding health facility delivery and home delivery. Further, although participants understood the benefits of delivering in a health facility, they said that the negative attitudes and disrespectful care they received from health workers was a major deterrent to seeking services in health facilities. In contrast, participants valued respectful, caring, and patient-centered care from TBAs, and they recommended training for health workers in better communication with patients and more respectful service. Participants also talked about some of the poor beliefs and practices in their communities that greatly influenced the decisions they made during their pregnancy journeys.

8 CONCLUSIONS AND RECOMMENDATIONS

During your last pregnancy at what point in time did you make the decision of where to deliver?
(n = 54)



This study sought to investigate individual and contextual factors that influence women's decisions and actions with regard to place of delivery in Kenya. A team of interviewers conducted 24 focus group discussions, 24 key informant interviews, and 60 in-depth interviews in Baringo, Kisumu, Migori, Nakuru, Samburu, and Turkana Counties. In working to uncover beliefs and nuances that are sometimes difficult to discern from quantitative metrics, the study has intended to provide findings for an audience of practitioners and policymakers. In particular, the report has aimed to present findings in ways useful to USAID/Kenya and their partners in designing and refining programs and interventions relating to maternal and child health.

Data from the study suggest that place of delivery is not as simple as grouping women into the dichotomy of those who choose to deliver in a health facility and those who choose to deliver outside a health facility. Numerous factors influence place of delivery, and women do not necessarily always choose the place of delivery. Some of the influencing factors identified through this study include timing of labor, access to transportation, beliefs about health care more broadly, individual preferences, accessibility of health facilities, perceived and actual quality of care, and ability of health care providers to offer respectful and culturally sensitive services. Place of delivery among the participants also varied from pregnancy to pregnancy, suggesting that decision-making processes are complex and not simply influenced by a single factor at a single point in time.

In 2010, the Government of Kenya published a roadmap for accelerating the attainment of the Millennium Development Goals (MDGs) related to maternal and newborn health. This roadmap recognizes a continuum of interventions to support the delivery of optimal reproductive health services for women before, during, and after pregnancy. However, the roadmap also identifies challenges comparable to the challenges that emerged in the data from this study (MoPHS and MoMS 2010).

The first part of this chapter provides a summary of the conclusions from this study, organized by the three research questions. The second part of the chapter presents the conclusions in more detail and provides recommendations for action related to each conclusion.

8.1 Conclusions Organized by Research Questions

Chapter 4 presented women's narratives of delivery as shared by female study participants and the context in which women experience the pregnancy-to-delivery continuum. The chapter included analysis of male-only focus group discussions and discussed the geographic, transport, and financial challenges women face in seeking health care. Chapters 5, 6, and 7 discussed, respectively, participants' perceptions about health services and health facilities, tensions surrounding cultural beliefs and practices, and experiences relating to feelings during pregnancy. This final chapter presents conclusions and recommendations organized by the study's three research questions. Table 11 provides a summary of the conclusions.

Table 11 Summary of conclusions organized by research question

Research Question 1: How do pregnant women make and implement choices about where to deliver?
▪ Women tend to make choices about place of delivery at various points in time including before, during, and after pregnancy. Women's choices may change from one pregnancy to the next. ▪ Choices women make about delivery often occur as part of navigating competing beliefs and motivations, notably in relation to belief in both biomedical approaches and herbal medicines. ▪ Women often implement choices about delivery aware of the risks associated with HIV, but also influenced by the possibility of stigma and discrimination. ▪ Place of delivery decision-making is often gendered, with male partner involvement not automatic and sometimes limited.
Research Question 2: Why do pregnant women choose not to deliver in health facilities, even when such facilities appear to be available?
▪ Geographic and transport challenges play a role in why women sometimes deliver at home and not in a facility. The challenges are more intricate than simply distance to a health facility. ▪ Often women choose not to deliver in a health facility because there are likely to be associated direct or indirect costs as well as fees for services that are advertised as free. ▪ Negative experiences such as lack of respectful care and feeling stigmatized inform the decision-making process around place of delivery. ▪ Many women prefer the services and support that TBAs offer.
Research Question 3: What individual factors and contextual factors beyond individual agency influence women's behavior with regard to where they deliver?
▪ Men and women often have different views on how things work in a marriage or partnership. ▪ How health facility staff react to convictions women have surrounding cultural beliefs influences women's behavior about place of delivery. ▪ Food elicits a range of cultural beliefs, which have the potential to push women toward health facility delivery as much as they have the potential to deter women from health facility delivery. ▪ Women's behavior with regard to place of delivery includes having to navigate social support acting as a productive influence in some instances and a negative influence in others. ▪ Often the context for women includes financial reliance on a male partner. That reliance and whether or not the expectation is met influences women's thinking around place of delivery.

8.2 Actionable Recommendations

Data from the 2014 KDHS suggest that Kenya has made progress in improving the availability and use of maternal health services, including 61% prevalence of health facility delivery (KNBS 2015). These data also indicate that place of delivery varies across Kenya's counties, with rural counties that have low population density recording lower rates for health facility delivery. In an effort to continue to reduce maternal mortality and increase health facility delivery, the findings from this study in Baringo, Kisumu, Migori, Nakuru, Samburu, and Turkana Counties point to several key conclusions and recommendations.

These recommendations are not "one size fits all" but will need to be adapted contextually to address the barriers and opportunities in each county. A coordinated and inclusive effort will be required to review and implement recommendations. Kenya's national reproductive health strategy defines a comprehensive range of stakeholders representing institutions and partners at national and subnational levels (MoPHS and MoMS 2009). The roles of these stakeholders include policy formulation and resource mobilization (Ministry of Health and development partners), program implementation and supervision (subnational health management teams), and participation in activities to promote individual reproductive health (communities, households, and individuals). The strategy also highlights the unique challenges experienced by pastoralist communities living in "hard-to-reach" regions and the implications of these challenges to the coverage of reproductive health services. With a goal of fostering a supportive environment for health facility delivery, it will be crucial to engage local stakeholders such as health facility staff, community leaders, TBAs, and households and mothers to help prioritize actions, identify local solutions, and ensure ownership and sustainability

Research Question 1: How do pregnant women make and implement choices about where to deliver?

Decision-making occurs over time

Often, the participants described decisions about place of delivery and delivery less as a choice and more as something that simply happens. Given these descriptions, the data suggest some degree of matter-of-factness around place of delivery and delivery. In addition, as noted in the opening graphic for this chapter, some women reported that they make the decision about where to deliver at certain points or at all points during their pregnancy, while other women reported that they do not think at all about the decision of where to deliver while they are pregnant.

> ***Recommendation:*** *Ensure that interventions focus on targeting women throughout the pregnancy-to-delivery continuum.*

Navigating competing motivations

Kenya's national reproductive health policy lists responsiveness of health services to the needs of the consumers among its eight core principles; however, achieving this aim remains unaccomplished (MoH 2007). Understanding perceptions about health care and experiences with health facilities is an important part of examining the actions and choices women make in relation to delivery. Health promotion along with prevention and care services form an integrated experience for the users. That experience then includes choices about use of ANC and delivery services influenced by previous interactions with both traditional and biomedical care services.

Data from the study suggest that women commonly conceptualize health care and take action by navigating multiple perspectives and competing motivations. The dualities are in relation to, for example:

- Seeking services from a health facility while also taking traditional herbs.
- Having greater interest in the goods health facilities provide rather than the services.
- Seeking ANC to be on record with a health facility in case a delivery at home requires emergency services.
- Experiencing shortcomings with government health care policies and services, including instances of corruption.

> ***Recommendation:*** *There is need for continued recognition among health care professionals that biomedical training and biomedically based advocacy are not necessarily the only elements and motivating factors in guiding individuals to take preventative and corrective health-related actions. To move beyond recognition and toward action, health facility staff might consider problem-solving activities such as producing educational materials focused on understanding the potentially beneficial and potentially harmful effects of herbal medications.*

Limited options for services to address fears and insecurities

The pregnancy-to-delivery continuum is not always a journey that follows a simple path. Women often face a range of challenges, some of which revolve around fears and insecurities. Other challenges are unpredictable such as early onset of labor or unexpected labor complications. Data from the study suggest that, while family members often provide support, the options are limited for professional services to help women understand and address their fears and insecurities. In such a context, the likelihood increases that women will suppress their fears and insecurities.

> ***Recommendations:*** *Increase efforts to equip health facility staff with training and tools that help to de-stigmatize pregnancy-related fear and insecurity. Ensure that health facilities have trained professionals on staff who can offer support and services in instances when women experience fear or insecurity in relation to their pregnancy, or their health status more broadly.*

Avoiding stigma, HIV awareness, and fear of mistreatment or judgment

Reproductive health services are important entry points for HIV services. The priority actions defined in Kenya’s national reproductive health policy (MoH 2007) include both integration of HIV/AIDS information and services into reproductive health services at all levels of health care and integration of opt-out HIV testing as part of a comprehensive antenatal care package.

The data from the study indicate that in some instances participants sought TBA services to avoid HIV testing that they believed would be required in a health facility. In addition, many participants expressed the belief that many forms of stigma and discrimination potentially occur at health facilities, for example in relation to tribe, socioeconomic status, and circumstances of being pregnant.

Recommendations: *Combatting stigma around HIV and other forms of stigma requires continued work by government agencies and donor-funded programs, including:*

- *Training and sensitization for health facility staff in relation to respectful and non-judgmental care, confidentiality, disclosure, testing, and reduction of perceived fears.*
- *Training, tools, and support for health facility staff to engage target communities and local organizations to reduce stigma and discrimination surrounding HIV.*
- *Community engagement and strategies focused on acknowledging and combatting all forms of stigma and discrimination.*

Gendered views regarding male partner involvement in pregnancy and delivery health care

One goal in Kenya's national roadmap for accelerating the attainment of the MDGs related to maternal and newborn health centers on promoting greater involvement from male partners as part of the pathway to increasing access to and use of maternal and newborn health services (MoPHS and MoMS 2010).

Awareness among the male participants in this study about the importance of women's health during pregnancy and delivery appeared to be high; however, the level of involvement from male partners in decisions and planning appeared to happen to varying degrees and in limited ways. Many of the comments from the participants (both male and female) indicated a belief that maternal health care falls primarily in women's domain. A gendered view of maternal health such as this potentially creates barriers for women in the context of the decisions and choices that occur during the pregnancy-to-delivery continuum. A few of the male participants deviated from a gendered view of maternal health, suggesting that involving men in maternal health programming is feasible, if not something men are increasingly seeking out.

Recommendations: *Establish both long-term and short-term strategies and programming to support women's empowerment and apply gender transformative approaches, including:*

- *Working with communities and household members to develop a shared understanding of gendered norms and identify practices that perpetuate inequality.*
- *Developing a plan of action to address inequalities and harmful practices.*
- *Engaging male household members to support women in their delivery decisions and needs during and after pregnancy.*
- *Moving toward transforming unequal gender relations to promote shared power, control of resources, and decision-making.*
- *Promoting equality for male and female infants with the longer-term vision of increasing the social capital of girls as members of and contributors to the household.*
- *Examples of USAID projects that have taken a gender transformative approach include SPRING in Senegal,[3] FALAH in Pakistan,[4] and the DREAMS Initiative in Lesotho.[5]*

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[3] https://www.spring-nutrition.org/region-and-country/senegal
[4] http://evidenceproject.popcouncil.org/case-study-of-successful-male-engagement-in-family-planning-in-pakistan/
[5] https://www.youtube.com/watch?v=Tv2a2oovu6o&feature=youtu.be

Research Question 2: Why do pregnant women choose not to deliver at health facilities, even when such facilities appear to be available?

Geographic and transportation challenges

Across each of the six counties, the data makes clear that transportation challenges play a prominent role in why many women choose home delivery over health facility delivery. Transportation challenges are multilayered and relate to distance to health facilities, access to transport services, affordability of transport services, reliability of transport services, poor quality or lack of roads, and unmet expectations for 24-hour ambulance services.

Recommendations: *Sustainable, structural, and long-term improvements around transportation would likely require considerable resources and time. Some possible focus areas and short-term actions might center on the following:*

- *Making transportation available at night out of recognition that the onset of labor is unpredictable.*
- *Increasing accommodation options in or adjacent to health facilities to enable women to travel during the day when transportation is more readily available.*
- *Ensuring thoughtful consideration of the pros and cons relating to the recent influx of motorbikes as a form of transportation for women to access health facilities.*

Free maternity care is not always free

Kenya's *Linda Mama* program for free maternity services aims to expand access to maternal and newborn health services through financial protection. To promote transparency in charges levied for health services, the Ministry of Health requires the public display of essential information on fee schedules at all health facilities (MoPHS and MoMS 2009). Data from the study suggest that individuals do not always fully realize the intended benefits of these policies. Participants reported incurring costs broadly classified as:

- Indirect costs, in cases where women incurred transport costs enroute to health facilities.
- Hidden costs, in cases where women incurred out-of-pocket payments for items or services that were found to be unavailable in public health facilities.
- Fees related to corruption in cases where women were directed (by health facility staff) to make undocumented payments in order to access otherwise free services in health facilities.

Recommendations: *Addressing these challenges will require complex solutions. Government agencies and partners planning interventions for maternal health services might consider:*

- *Assessing cost barriers for health facility delivery by investigating local barriers to implementing the Linda Mama program.*
- *Engage local health facilities and their partner communities in current experiences and expectations for benefiting from the Linda Mama program.*
- *Mobilizing community liaisons and community advocates who understand government policies and services and can translate this to women and their households.*

- *Promoting ethical practices and accountability among health care workers through approaches such as collection of immediate anonymous client feedback.*
- *Considering supporting voucher or reimbursement programs to offset transport costs in settings where these costs are a barrier to access.*
- *Assisting local government officials to invest in forecasting needs for maternal health services to ensure availability of essential commodities in health facilities.*
- *Increasing the number of health facilities accredited under the Linda Mama program (including private and faith-based health facilities).*

Expectation of support and respectful maternal care not always met

Kenya's national reproductive health strategy prioritizes activities aiming to both attract clients to use health facilities and to facilitate interaction and feedback between health care providers and those seeking services (MoPHS and MoMS 2009). Although this study did not involve an audit of the services provided in health facilities, nearly all participants described examples of when they felt health care providers in facilities mistreated them. Further, the data suggest that during pregnancy women turn to health care providers to provide biomedical-related services as well as psychosocial support, and have an expectation of being treated respectfully. Many participants indicated that health facilities struggle to provide psychosocial support and often do not treat patients with respect.

Recommendations: *Continued training around the importance of respectful maternal care and effective interpersonal communication by health care providers, including:*

- *Advocating to medical schools and nurses training programs the importance of skill building in relation to providing services with empathy and compassion.*
- *Training and tools for health facility staff around the provision of culturally sensitive care and support during pregnancy and delivery.*
- *Working with and including TBAs in efforts to both establish procedures and best practices around respectful maternal care and implement awareness and behavior change programs.*
- *Attending to the practice of quality audits to encourage adoption of desired behaviors and changed attitudes among health facility staff.*

Prominence of and preferences for TBAs

The current national policy does not recognize TBAs as providers of skilled care. Instead, the policy characterizes TBAs as individuals who promote birth-preparedness, identify potential complications, make referrals, provide postnatal care, and assist in registering births (MoH 2007). The participants often described TBAs as an attractive option because they are warm, comforting, and in general provide the opposite of their experiences with unfriendly and disrespectful health care providers in health facilities. Part of what appeared to be attractive for the participants centered on the ability of TBAs to develop personal connections and willingness to be patient-centered in providing care and support.

Recommendations: *Given the strong and valued role of TBAs, increased discussions among policymakers and stakeholders concerning how to proactively engage TBAs and enhance their role in health facilities might prove beneficial. In some cases, TBAs might be a valuable link between health facilities and communities. Moving in these directions likely will require additional training for TBAs as part of ensuring safe practices, coordinating key health messages, and possibly restructuring tasks to facilitate ways for TBAs to work alongside health care workers as birth companions to mothers who provide assistance during delivery.*

Research Question 3: What individual factors and contextual factors beyond individual agency influence women's behavior with regard to where they deliver?

Negotiating decisions and power dynamics in a marriage or partnership

The data, both overall and in considering male and female perspectives comparatively, reveal a range of views, including different interpretations of how things work in a marriage or partnership. In particular, some of the responses from male participants and from female participants provide contrasting viewpoints in terms of who makes decisions regarding maternal health and what constitutes optimal and sufficient male partner involvement in maternal health matters.

Recommendation: *Use the prism of gender equity to ground and advance maternal health programs promoting male partner involvement in maternal health. Programming of this type might target men as well as couples, and consider activities and training in relation to joint decision-making, financial management, life skills, communication and conflict resolution, and role recognition and reversal exercises.*

Hesitancy of health facilities to accommodate for traditional beliefs and practices

The data suggest that many barriers to health facility delivery revolve around the reluctance of health care providers to accommodate clients' traditional beliefs and practices. In particular, the participants reported that sometimes SBAs are dismissive of traditional herbs and lack understanding of cultural beliefs about birthing positions and treatment of the placenta. Thus, some participants indicated they prefer to deliver with TBAs who know about and are willing to accommodate these types of traditional beliefs and practices.

Recommendation: *Health care providers and community members should continue to embrace both SBAs and TBAs, acknowledging that each play an important role in the lives of women. Such an approach should center on the following*

- *Making clear distinctions regarding the role of the SBA and the role of the TBA and facilitating opportunities for SBAs and TBAs to work together.*
- *Establishing a comprehensive approach to care, including thoughtful attention to traditional beliefs and practices relating to pregnancy, delivery, and postpartum.*
- *Ensuring ways for SBAs, TBAs, and the women they interact with to have appropriate forums to provide feedback and suggestions.*

Conflicting views and concerns about food-related beliefs and practices

The participants described numerous cultural and traditional practices revolving around food, and questioned those that place restrictions on food beneficial for pregnant women. Some participants noted discrepancies between instructions they receive at health facilities and beliefs that restrict the consumption of certain foods. Aversion to these practices often made it more likely for some participants to deliver in a health facility. That is, some women preferred health facility delivery to delivery at home because they would not have to participate in post-delivery traditional practices that restrict food consumption.

Recommendation: *Community-based programs and interventions should continue to emphasize the importance of dietary diversity and work with community leaders to limit practices that restrict the consumption of foods that are beneficial for women. Social and behavior change communication should reach beyond individual women to also include community leaders, household members, and TBAs.*

Shifting terrains and varied degrees of and desire for social support

Data from the study reveal a range of views about maternal health broadly and place of delivery specifically. A diversity of views is not surprising in the context of the extensive efforts over many years to improve awareness around maternal health and to advocate for the uptake of optimal practices. Many participants acknowledged that their views have changed over time in response to the influence of health care professionals, community leaders, and family members. In addition, the data suggest that the familial context for participants varies; as do their beliefs about the role of families. In consideration of this variation, it appears that the terrain for women is ever-evolving, yet the need for pathways to seek additional social support or break away from harmful social support is constant.

Recommendation: *Strategies and programs focused on maternal health might consider the inclusion of peer-to-peer support networks, collectives, care groups, and other ways to connect women (and men) with their trusted sources.*

Potential reliance on financial support from male partners

Data from the study indicate that family, friends, community members, and TBAs function as sources of support during pregnancy, delivery, and postpartum, with male partners and mothers-in-law the primary sources. Many participants stated that they expected their male partners to provide financial support, whereas female family members would provide support in relation to household chores. In several instances, the participants provided examples of male partners who were unable to fulfil their responsibility due to poverty, obligations to other families, distance, or unwillingness. The participants also reported an increasing number of female-headed households or single mothers, and noted that these women have the most challenges due to limited financial support.

Recommendation: *Interventions or programs aimed at improving maternal and child health should increase efforts to target single mothers and women who do not have traditional support systems. Such programs should concentrate on postpartum support, as women often have to return to strenuous working conditions shortly after delivery.*

8.3 Concluding Statement

The conclusions from this study recognize that contextual factors and decision-making pertaining to place of delivery are complex and do not necessarily occur at a single point in time. The pregnancy-to-delivery continuum follows an ever-shifting terrain, influenced by myriad individual and collective beliefs, perceptions, tensions, and experiences. In summary, specific conclusions include:

- Favorable views about seeking health services at health facilities coexist with interest in traditional approaches, notably the use of herbs, and hesitancy to position health care solely in biomedical terms. Women have concerns that, increasingly, health services and health facilities present challenges due to poor quality of care, corruption, and hidden costs.

- Women hold TBAs in high esteem and often turn to them when SBAs are not accessible, and in instances when SBAs lack knowledge about cultural beliefs and practices. Women potentially view health facility delivery as a means to avoid food-related customs practiced in their communities. Non-food-related customs aligned to religious, cultural, and tribal beliefs represent a key factor shaping the choices and actions women make about place of delivery.

- While pregnant, women sometimes feel insecure and have fears regarding both health facility delivery and home delivery. Concerns about inconsistent respectful maternal care at health facilities and potentially variable support from male partners exacerbates what women feel and experience, and in turn, shape decisions about place of delivery.

Actionable recommendations emerging from the study call for improving the quality of and accessibility to health care while also finding ways for women and their partners to adopt a more health facility-centered approach to maternal care. In summary, specific recommendations include:

- Continued and coordinated training for health facility staff regarding respectful maternal care, including a focus on increasing appreciation for nonbiomedical perspectives, alleviating fears and insecurities, combatting (not exacerbating) stigma, and promoting gender equity.

- Establish and act on both short-term and long-term strategies to overcome transportation challenges and financial burdens relating to indirect and hidden costs that limit access to health facilities.

- Maintain balanced and inclusive strategies for promoting health facility delivery, including recognition that many women and their male partners will be hesitant to seek health services at health facilities if health facilities are dismissive of cultural beliefs and practices.

Neither the conclusions nor recommendations are “one size fits all”; instead, these insights represent a pathway to galvanize momentum and facilitate a commitment to take positive steps forward. Past and present strategies and programs put into operation by USAID/Kenya, the Government of Kenya, and their partners have made substantial progress in improving the uptake of optimal maternal and child health practices. Research studies such as this one can make a valuable contribution to knowledge about both the context in which women experience pregnancy and delivery and the specific challenges they face along the pregnancy-to-delivery continuum.

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APPENDICES

Appendix 1 English focus group discussion and interview guides

Appendix 2 NVivo code book

Appendix 3 Responses to demographic questions for in-depth interview participants

Appendix 3.1 Characteristics of the in-depth interview participants
Appendix 3.2 Tribe reported by in-depth interview participants by county
Appendix 3.3 Place of last delivery by level of education for in-depth interview participants

Appendix 4 Responses to yes-no questions for key informant and in-depth interview participants

Appendix 4.1 General perceptions regarding health services
Appendix 4.2 General perceptions regarding pregnancy
Appendix 4.3 General perceptions regarding delivery
Appendix 4.4 General perceptions regarding social and family support

Appendix 5 Responses to yes-no questions for in-depth interview participants by place of last delivery

Appendix 5.1 General perceptions regarding health services by place of last delivery
Appendix 5.2 General perceptions regarding pregnancy by place of last delivery
Appendix 5.3 General perceptions regarding delivery by place of last delivery
Appendix 5.4 General perceptions regarding social and family support by place of last delivery

Appendix 6 Kenya Master Health Facility List data for the six counties selected for the study

Appendix Table 1 **English focus group discussion and interview guides**

FOCUS GROUP DISCUSSION (FGD) ~ INTERVIEW GUIDE

RECORD KEEPING	
Date (dd/mm/yyyy)	
Research Assistant Number	
County Name	
Sub-County Name	
Ward Name / Number	
Community Unit	
Focus group discussion with	Women Men
Start time of focus group discussion	: □ AM □ PM
End time of focus group discussion	: □ AM □ PM
Total focus group discussion time	Hour(s) Minutes

INSTRUCTIONS

The focus group discussion will have been pre-arranged. Proceed as follows:
1) Prior to the focus group discussion, fill in the record keeping table as possible
2) Upon arrival, introduce yourself, be polite and appreciative
3) Follow the informed consent protocol

After obtaining consent from participant(s) and continuing in introductory mode, proceed as follows:
1) Use the tools that matches the interview type
2) Be sure you have a pencil or pen to take any notes

After completing the interview and thanking the participant(s), proceed as follows:
1) Note the end time of the focus group discussion in the record keeping table
2) Fill out the documenting observations form
3) Prepare this set of paper and the audio file for submission to the head office
4) Write the audio file name / interview code in the upper right corner of each page

REMINDER: All interview guides are in relation to these research questions:
1) How do pregnant women make and implement choices about where to deliver?
2) Why do pregnant women choose not to deliver at health facilities, even when such facilities appear to be available?
3) What individual factors and contextual factors beyond individual agency influence women's behaviour with regard to where they deliver?

DOCUMENTING OBSERVATIONS *What you observe during an interview can be as valuable as the answers to the questions you ask.*	
Date	
Research Assistant Number	
County Name	
Sub-County Name	
Ward Name / Number	
Community Unit	

TIPS FOR BEING A GOOD OBSERVER

- Pay attention to your surroundings. Particularly household layout and specific objects.
- Think about how you would describe where you are and if it looks different than expected.
- Take note of the interviewees body language. Do they laugh? Ask questions? Seem bored?
- Be inquisitive with your eyes and think descriptively throughout the interview.

INSTRUCTIONS

Use the space below and on the back of this page to write down your observations. Note what you see and think about your observations in relation to the four questions below.

1. What surprised you and why?
2. How would you describe the overall health and health facility context in the area?
3. What examples of resourceful innovative coping strategies did you see?
4. How do geographical surroundings (i.e., water, rain, trees, etc.) impact people's lives?

___

BACKGROUND

Reminder
Gathering the information in the table below is for your benefit. Think of it as an ice breaker

#	Age	Sex	Occupation/Community Role	No. of children	Ages of children/ Age range of children	Pregnant (yes/no)
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

REMINDER
Be sure to discuss with the group the importance of respecting the privacy of all participants, particularly

- **Do not reveal who else was a focus group discussion participant to others in the community**
- **Do not describe to others in the community what individual focus group discussion participants said.**

Map out where the participants are sitting in relation to you

PART 1 HEALTH CARE SERVICES (thoughts, options, and choices)

What are treatment and health care services like in this community?

Possible Probes
What types of things work well?
What does not work well?
What are some possible ways that improvements could be made?

How do women in this community feel about seeking health care services?

Possible Probes
Where do most women seek health care services?
How much influence do family members have on decisions women make about health care services?

What do you feel are some of the health matters that are most important for women?
[Please explain in detail]

Possible Probes
Do family members generally feel it is important for women to seek health care?
Are there ever disagreements about women seeking health care? If so, can you explain?

PART 2 PREGNANCY (experiences, support, and choices)

In general, and in this community, what are the experiences of women during pregnancy?

Possible Probes
What is common in terms of looking after their own health and the health of the baby?
What types of treatments do women seek?
Where do they go for treatments?
Who provides treatments?

What influences the health care decisions women make during pregnancy?

Possible Probes
Are their certain people who help women make the decisions?
Do you think women in this community are happy with the decision-making process?

What do you feel are the most important things for women to do while pregnant to ensure the health of the mother and the baby?

Possible Probes
What do you feel are the most important things for women to not do?
Do you think women in this community understand the most important things to do (and not do)?
Who helps women understand what to do and not do?

Do women in this community face any challenges during pregnancy?

Possible Probes
If so, what types of challenges?
Are there any specific beliefs or common practices you feel have negative impacts for women?
What do women do to overcome challenges?
Who are the people who help women overcome these challenges?

PART 3 DELIVERY (women's practices, realities, and choices)

Where is the most common place that women in this community deliver?

Possible Probes
What are the general views women have about delivery at a hospital?
What are the general views women have about delivery at home?

Given the options of delivery at a hospital and delivery at home, what do you think are the key reasons behind the choices being made? [Please explain in detail]

Who generally makes the decisions about where to deliver?

Possible Probes
Who helps women to make the decisions?
What are the main factors that influence the choices about where to deliver?
Are women involved in making decisions about delivery?
Do you think women are happy with the delivery options available?

Are there any social or cultural factors that influence women's decisions about where to deliver?

Possible Probes
Can you tell me about some of the positive social and cultural factors?
Can you tell me about some of the negative social and cultural factors?

Are there any challenges women in this community face in relation to delivery?

Possible Probes
What are some of the challenges? How do women overcome these challenges?

PART 4 SOCIAL AND FAMILY SUPPORT

Often in any family or community, there are different viewpoints about maternal and child health. What are some of the common viewpoints in this community?

Possible Probes
Are some of the viewpoints conflicting? In what ways?
How do you think women in this community navigate conflicting viewpoints and suggestions?
Who do you think has the final say?

Do you think women in this community feel strong and confident to ask health service providers questions? [Please explain in detail]

Possible Probes
Do women know how to be an advocate for themselves as the patient?
Do you think are any things about a health care facility that scare or confuse women?

In this community, how is a woman treated after child birth?

Possible Probes
What are the expectations for women following birth? When do women go back to work?

Can you think of some of the NGO or donor projects specific to MCH in this community?

Possible Probes
What are some of the things they done that have worked? Have not worked?

From your experience, what do think is needed from the government to improve the services to ensure that women can be healthy during pregnancy and delivery? What stops these improvements from happening?

KEY INFORMANT INTERVIEW (KII) ~ INTERVIEW GUIDE

RECORD KEEPING	
Date (dd/mm/yyyy)	
Research Assistant Number	
County Name	
Sub-County Name	
Ward Name / Code	
Community Unit	
Start time of interview	: □ AM □ PM
End time of interview	: □ AM □ PM
Total interview time	Hour(s) Minutes
Facility-Based Key Informant [indicate position/job]	
Non Facility-Based Key Informant [indicate position/job]	

INSTRUCTIONS

The interview will have been pre-arranged. Upon arrival, proceed as follows:

1) Introduce yourself, be polite and appreciative
2) Follow the informed consent protocol

After obtaining consent from participant(s) and continuing in introductory mode, proceed as follows:

3) Use the tools that matches the interview type
4) While chatting informally fill in the record keeping table as possible

After completing the interview and thanking the participant(s), proceed as follows:

5) Note the end time of the interview in the record keeping table
6) Fill out the documenting observations form
7) Prepare the record keeping, close-ended questions, and audio file for submission
8) Write the audio file name / interview code in the upper right corner of each page

REMINDER: All interview guides are in relation to these research questions:

4) How do pregnant women make and implement choices about where to deliver?
5) Why do pregnant women choose not to deliver at health facilities, even when such facilities appear to be available?
6) What individual factors and contextual factors beyond individual agency influence women’s behaviour with regard to where they deliver?

DOCUMENTING OBSERVATIONS *What you observe during an interview can be as valuable as the answers to the questions you ask.*	
Date	
Research Assistant Number	
County Name	
Sub-County Name	
Ward Name / Code	
Community Unit	

TIPS FOR BEING A GOOD OBSERVER

- Pay attention to your surroundings. Particularly household layout and specific objects.
- Think about how you would describe where you are and if it looks different than expected.
- Take note of the interviewees body language. Do they laugh? Ask questions? Seem bored?
- Be inquisitive with your eyes and think descriptively throughout the interview.

INSTRUCTIONS

Use the space below and on the back of this page to write down your observations. Note what you see and think about your observations in relation to the four questions below.

5. What surprised you and why?
6. How would you describe the overall health and health facility context in the area?
7. What examples of resourceful innovative coping strategies did you see?
8. How do geographical surroundings (i.e., water, rain, trees, etc.) impact people's lives?

____

BACKGROUND

INTRODUCTION AND TRANSITION

- **Thanks so much for agreeing to chat with me.**
- **I would like to begin by asking you a few background questions about the work you do and your role in the community**

Can you describe your job? What does your work entail? What is your area of expertise?

How long have you been working in this capacity?

What are some of things you find rewarding about your job?

What are some of the things you find frustrating about your job?

PART 1 HEALTH CARE SERVICES (women's thoughts, options, and choices)

INTRODUCTION AND TRANSITION
- **I am interested to get a sense from you about how things are in this community**
- **To start, I would like to ask some questions about health care services in general**
- **I shall begin with a few yes-no questions. Please first just answer yes or no for each question, then we will have a chance to chat about things in more detail**
- **With each of these questions, I am asking about what you think is the case in this community**

		Yes (1)	No (2)
HCS1	Do you think there are sufficient hospitals in this community?		
HCS2	Do you think hospitals in this community are easily accessible?		
HCS3	Do you think hospitals in this community provide good services?		
HCS4	Do you think women in this community trust services providers at hospitals?		
HCS5	Do you think women in this community ever feel afraid about going to a hospital?		
HCS6	Do you think anyone discourages women in this community from going to a hospital?		
HCS7	Do you think anyone encourages women in this community to go to a hospital?		
HCS8	Do you think women in this community commonly seek health care services in hospitals?		
HCS9	Do you think women in this community commonly seek health care services outside a hospital?		

TRANSITION
- **Great. Thanks for those responses**
- **Now I would like to speak in more detail about health care services in this community, and the approach women take concerning health care services**

What do women in this community do when they are sick? [Please explain in detail]

Possible Probes
How do women in this community feel about seeking treatment for themselves?
Do family members have an influence on decisions women make about seeking treatment? If so, what types of influence do family members have on decisions women make about seeking treatment?
How strong is influence from the family?

Do women in this community feel that there are points in time when it is particularly important to seek treatment for themselves?

Possible Probes
Do you think their understanding in this regard is adequate? Why or why not?

What is your general view on health care services?

Possible Probes
What things work well?
What are challenges?

In general, how do women in this community feel about health care facilities? [Please explain in detail]

PART 2 PREGNANCY (women's experiences, support system, and choices)

INTRODUCTION AND TRANSITION

- **Now I would like to ask some questions about pregnancy**
- **As before, I shall begin with a few yes-no questions. Please first just answer yes or no for each question, then we will have a chance to chat about things in more detail**
- **With each of these questions, I am asking about what you think is the case in this community**

		Yes (1)	No (2)
PRG1	While pregnant, do you think there are times the family is supportive of the expectant mother?		
PRG2	While pregnant, do you think there are times a family is not supportive of the expectant mother?		
PRG3	Do you think women in this community ever feel afraid during pregnancy?		
PRG4	Do you think anyone discourages women in this community from going to a hospital during pregnancy?		
PRG5	Do you think anyone encourages women in this community to go to a hospital during pregnancy?		
PRG6	Do you think women in this community are involved in the decision whether or not to go to a hospital during pregnancy?		
PRG7	Do you think women in this community feel a mother's life is at risk during pregnancy or delivery?		
PRG8	Do you think women in this community feel a baby's life is at risk during pregnancy or delivery?		
PRG9	Do you think women in this community have any regrets about the decisions they have made with past pregnancies?		

TRANSITION

- **Great. Thanks for those responses**
- **Now I would like to speak about pregnancy and how women in this community approach being pregnant**

In the capacity of your work, what can you tell me about women's experiences during pregnancy?

Possible Probes
Who are the key people who give support? Who influences the decision-making during pregnancy?
Do you think women in this community are happy with the decision-making process?

Do women face challenges during pregnancy in this community? [Please explain in detail]

Possible Probes
If so, what types of challenges? How do women try to do to overcome these challenges?

Are there any specific beliefs or common practices in this community that you feel have impacts for women during pregnancy?

Possible Probes
Can you tell me about some of the positive social and cultural beliefs and practices?
Can you tell me about some of the negative social and cultural beliefs and practices?

In general, do you think women in this community understand the most important things to do while pregnant? And not to do?

Possible Probes
What facilitates or impedes women in this community to be able to focus on their own health and the health of their baby during pregnancy?

PART 3 DELIVERY (women's practices, realities, and choices)

INTRODUCTION AND TRANSITION
- **Now I would like to ask some questions about delivery**
- **As before, I shall begin with a few yes-no questions. Please first just answer yes or no for each question, then we will have a chance to chat about things in more detail**
- **With each of these questions, I am asking about what you think is the case in this community**

		Yes (1)	No (2)
DLV1	Do you think women in this community feel a hospital is a good option for delivery?		
DLV2	Do you think women in this community feel a hospital is the only good option for delivery?		
DLV3	Do you think most women in this community deliver in hospitals?		
DLV4	Do you think the location of the hospital influences the decisions women make about where to deliver?		
DLV5	Do you think the type of service providers at a hospital influence the decisions women made about where to deliver?		
DLV6	Do you think health care facility workers in this community discourage delivery outside a hospital?		
DLV7	Do you think people in this community discourage delivery at hospital?		
DLV8	Do you think women in this community have any regrets about the decisions they have made with past deliveries?		

TRANSITION
- **Great. Thanks for those responses**
- **Now I would like to speak in more detail about delivery and how women in this community approach delivering their babies**

What are some of the delivery options available in this community? [Please explain in detail]

Possible Probes
Can you tell me more about each of these options?
In this community, what are the general views about each of these options?

Who generally makes the decisions about where to deliver?

Possible Probes
What are the main factors that influence the choices about where to deliver?
Are women involved in making decisions about delivery?
Do you think women are happy with the delivery options available?

Are there any challenges women in this community face in relation to delivery?

Possible Probes
What are some of the challenges?
How do women overcome these challenges?

Are there any specific beliefs or common practices in this community that you feel have negative impacts for women in terms of choices and options for delivering a baby? [Please explain in detail]

PART 4 SOCIAL AND FAMILY SUPPORT

INTRODUCTION AND TRANSITION

- **To bring things to a close, I would like to ask some broad questions about perceptions and beliefs**
- **As before, I shall begin with a few yes-no questions. Please first just answer yes or no for each question, then we will have a chance to chat about things in more detail**
- **With each of these questions, I am asking about what you think is the case in this community**

		Yes (1)	No (2)
SFS1	In the first few weeks after delivery, do you think women in this community feel that their family is supportive?		
SFS2	In the first few weeks after delivery, do you think women in this community ever feel afraid?		
SFS3	Do you think women in this community feel that service providers at health care facilities offer good advice?		
SFS4	Do you think women in this community feel that service providers at health care facilities explain things well?		
SFS5	Do you think service providers at hospitals treat women with respect during pregnancy and delivery?		
SFS6	Do you think women in this community feel that their family members offer good advice regarding their health?		
SFS7	Do you think women in this community feel that their family members ever make it hard for them to be a good mother?		

TRANSITION

- **Great. Thanks for those responses**
- **Now I would like to speak in more detail about perceptions and beliefs among women in this community and across the community in general**

Often in any family or community, there are different beliefs about maternal health. What are some of the common beliefs in this community?

Possible Probes
Are some of the viewpoints conflicting? In what ways?
How do you think women in this community navigate conflicting viewpoints and suggestions?
Who do you think has the final say?

Do you think women in this community feel strong and confident to ask health care providers questions?

Possible Probes
Do women know how to be an advocate for themselves as the patient?
Do you think are any things about a health care facility that scare or confuse women?

In this community, how is a woman treated after child birth?

Possible Probes
What are the expectations for women following birth? When do women go back to work?

Can you think of some of the NGO or donor projects specific to MCH in this community?

Possible Probes
What are some of the things they done that have worked?
What are some of the things they done that have not worked?

From your experience, what do you think is needed from the government to improve the services to ensure that women can be healthy during pregnancy and delivery? What stops these improvements from happening?

IN-DEPTH INTERVIEW (IDI) ~ INTERVIEW GUIDE

RECORD KEEPING	
Date (dd/mm/yyyy)	
Research Assistant Number	
County Name	
Sub-County Name	
Ward Name / Number	
Community Unit	
Start time of interview	: □ AM □ PM
End time of interview	: □ AM □ PM
Total interview time	Hour(s) Minutes
Name of nearest health care facility	
Distance of nearest health care facility from household	Kilometers OR minutes to walk there

INSTRUCTIONS

The interview will have been pre-arranged. Proceed as follows:

3) Prior to the interview, fill in the record keeping table as possible
4) Upon arrival, introduce yourself, be polite and appreciative
5) Follow the informed consent protocol

After obtaining consent from participant(s) and continuing in introductory mode, proceed as follows:

5) Use the tool that matches the interview type
6) Be sure you have a pencil or pen to record the answers to the close-ended questions

After completing the interview and thanking the participant(s), proceed as follows:

9) Note the end time of the interview in the record keeping table
10) Fill out the documenting observations form
11) Prepare the recording keeping, close-ended question, and audio file for submission
12) Write the audio file name / interview code in the upper right corner of each page

REMINDER: All interview guides are in relation to these research questions:

7) How do pregnant women make and implement choices about where to deliver?
8) Why do pregnant women choose not to deliver at health facilities, even when such facilities appear to be available?
9) What individual factors and contextual factors beyond individual agency influence women's behaviour with regard to where they deliver?

DOCUMENTING OBSERVATIONS *What you observe during an interview can be as valuable as the answers to the questions you ask.*	
Date	
Research Assistant Number	
County Name	
Sub-County Name	
Ward Name / Number	
Community Unit	

TIPS FOR BEING A GOOD OBSERVER

- Pay attention to your surroundings. Particularly household layout and specific objects.
- Think about how you would describe where you are and if it looks different than expected.
- Take note of the interviewees body language. Do they laugh? Ask questions? Seem bored?
- Be inquisitive with your eyes and think descriptively throughout the interview.

INSTRUCTIONS

Use the space below and on the back of this page to write down your observations. Note what you see and think about your observations in relation to the four questions below.

9. What surprised you and why?
10. How would you describe the overall health and health facility context in the area?
11. What examples of resourceful innovative coping strategies did you see?
12. How do geographical surroundings (i.e., water, rain, trees, etc.) impact people's lives?

____

DEMOGRAPHICS

INTRODUCTION AND TRANSITION

- **Thanks so much for agreeing to chat with me**
- **I would like to begin by gathering some background information about you and your household**

About the study participant		
DMG1	How old are you?	
DMG2	What is your current marital status? 1. Married / partnered 2. Single 3. Widow 4. Divorced 5. Other (_________________________________)	If 2, skip to DMG4
DMG3	[If applicable] How old were you were when you first got married?	
DMG4	What is your primary occupation?	
DMG5	[If applicable] What is your husband's occupation?	
DMG6	Do you practice a specific religion? If so, which one? 1. No 2. Christian 3. Muslim 4. Other (_________________________________)	
DMG7	Which tribe do you most closely identify with? 1. Kikuyu 2. Luhya 3. Kalenjin 4. Luo 5. Kamba 6. Kisii 7. Mijikenda 8. Meru 9. Turkana 10. Masai 11. Samburu 12. Other: ____________________	
DMG8	What level of education did you reach? 1. None 2. Primary School 3. Secondary School 4. College or university	
About the household		
DMG9	How many family members live with you in the household?	
DMG10	How long have you lived in this house?	Months Years
DMG11	Who is the head of household [in relation to the participant]? 1. Grandfather 2. Grandmother 3. Father 4. Mother 5. Husband 6. Wife 7. Mother-in-law 8. Father-in-law 9. Brother-in-law 10. Sister-in-law 11. Participant is head of household 12. Other (_________________)	

Motherhood and pregnancy		
DMG12	How many times have you been pregnant?	
DMG13	How many children do you have (living children)?	
DMG14	How many boys?	
DMG15	How many girls?	
DMG16	Are you currently pregnant? 1 = yes; 2 = no; 3 = don't know	
DMG17	With your last pregnancy, how many times did you receive ANC services?	
DMG18	Of all of your pregnancies, how many times did you deliver at a hospital?	
DMG19	Of all of your pregnancies, how many times did you deliver outside a hospital?	
DMG20	What was the date of last delivery? [month and year]	
DMG21	Where did this last delivery occur? 1. Home 2. Public hospital 3. Private hospital 4. Missionary hospital 5. Other______________________________ Note the name of the hospital:	
DMG22	During your last pregnancy at what point in time did you make the decision of where to deliver? 1. Months 1 – 3 2. Months 4 – 6 3. Months 7 – 9 4. All 9 Months 5. Did not think about it	

TRANSITION

- **Great. Thanks for those responses**
- **Now I would like to move to the first part of the interview**

PART 1 HEALTH CARE SERVICES (thoughts, options, and choices)

INTRODUCTION AND TRANSITION
- **Now, I would like to ask some questions about health care services in general**
- **I shall begin with a few yes-no questions. Please first just answer yes or no for each question, then we will have a chance to chat about things in more detail**

		Yes (1)	No (2)
HCS1	Do you think sufficient hospitals exist in this community?		
HCS2	Do you think hospitals are easily accessible in this community?		
HCS3	Do you think hospitals in this community provide good services?		
HCS4	Do you trust service providers at hospitals?		
HCS5	Have you ever felt afraid about going to a hospital?		
HCS6	Has anyone ever discouraged you from going to a hospital?		
HCS7	Has anyone ever encouraged you to go to a hospital?		
HCS8	Do you think women in this community commonly go to a hospital for treatment?		
HCS9	Do you think women in this community commonly seek treatment outside a hospital?		

TRANSITION
- **Great. Thanks for those responses**
- **Now I would like to speak in more detail about health care services, and your experiences**

What do you do when you are sick? And why do you do that?

Possible Probes
Where do you go for help when you are sick?
What types of help do you receive?

When you have sought help regarding your health what has been your experience? [Please explain in detail]

Possible Probes
How did you find the quality of the care you received?

What do you feel are some of the health matters most important for women?

Possible Probes
Do members of your family feel it is important for women to seek health care?
Are there ever disagreements about women seeking health care? If so, can you explain?

In this community, are there a lot of options in terms of accessing health care services?

Possible Probes
What types of things do you feel are problems with health care services?
What are some possible ways that improvements could be made?

PART 2 PREGNANCY (experiences, support system, and choices)

INTRODUCTION AND TRANSITION
- **Now, I would like to ask some questions about pregnancy**
- **I shall begin with a few yes-no questions. Please first just answer yes or no for each question, then we will have a chance to chat about things in more detail**

		Yes (1)	No (2)
PRG1	While pregnant, at any point was your family supportive?		
PRG2	While pregnant, at any point was your family not supportive?		
PRG3	While pregnant, at any point did you feel afraid?		
PRG4	While pregnant, did anyone discourage you from going to a hospital?		
PRG5	While pregnant, did anyone encourage you to go to a hospital?		
PRG6	While pregnant, were you involved in the decision whether or not to go to a hospital?		
PRG7	During pregnancy, do you feel a mother's life could be at risk?		
PRG8	During pregnancy, do you feel the baby's life could be at risk?		
PRG9	Do you have any regrets about decisions you made with past pregnancies?		

TRANSITION
- **Great. Thanks for those responses**
- **Now I would like to speak in more detail about pregnancy, and what experiences you have had**

Let's talk about your last pregnancy. Can you tell me about what you were feeling? [Please explain in detail]

Possible Probes
Were you happy? Were you scared? How did your husband / family react?

What are the health care options in this community for pregnant women?

Possible Probes
What has been your experiences in seeking pregnancy-related health care or treatments?
What do you think are some of the good things about going to the hospital while pregnant?
Are there bad things as well?

What influenced the health care decisions you made during your last pregnancy?

Possible Probes
Were there people who helped you make the decisions?
Were there times you felt that people gave you bad advice, or they were having a negative influence?
Did you go for ANC? [Whether yes or no find out why]

What do you feel are the most important things for women to do while pregnant to ensure their own health and the health of the baby during pregnancy?

Possible Probes
What do you feel are the most important things for women to avoid when pregnant?
Who is the main people who help you to understand what you need to do to and not do to ensure you and your baby stay healthy during pregnancy?

Did you face any challenges during your last pregnancy?

Possible Probes
If so, what types of challenges? What did you do to overcome these challenges? Who helped you?

PART 3 DELIVERY (beliefs, realities, and choices)

INTRODUCTION AND TRANSITION

- **Now, I would like to ask some questions about when you deliver your baby**
- **Once again, I shall begin with a few yes-no questions. Please first just answer yes or no for each question, then we will have a chance to chat about things in more detail**

		Yes (1)	No (2)
DLV1	Do you think a hospital is a good option for delivery?		
DLV2	Do you think a hospital is the only good option for delivery?		
DLV3	Do you think most women in this community deliver in hospitals?		
DLV4	Did the location of the hospital influence your decision about where to deliver?		
DLV5	Did the type of hospital influence your decision about where to deliver?		
DLV6	Do you think hospital staff discourage delivery outside of a hospital?		
DLV7	Do you think people in this community discourage delivery at a hospital?		
DLV8	Do you have any regrets about decisions you have made with past deliveries?		

TRANSITION

- **Great. Thanks for those responses**
- **Now I would like to speak in more detail about delivery, and what experiences you have had**

With your last delivery, can you describe the experience? [Please explain in detail]

Possible Probes
Where was the delivery? Did anyone help you make the decision?
Who was with you? What was it like? What help did you receive?
Are there services or treatments you wish you would have received?

What do you think is the ideal place for delivery? Why?

Possible Probes
Are there other ideal places? Are you happy with the delivery options available in this area?
Who is the people you think should be with a woman when she delivers?
Who should not be with a woman when she delivers?

Are there any social or cultural factors that influence women's decisions about where to deliver? [Please explain in detail]

Possible Probes
Can you tell me about some of the positive social and cultural factors?
Can you tell me about some of the negative social and cultural factors?

What do you feel are the most important things for women to do in relation to delivery?

Possible Probes
What do you feel are the most important things for women to not do?
Who is the main people who help you to understand what you need to do to ensure you and your baby stay healthy during delivery?

Did you face any challenges during your last delivery?

Possible Probes
If so, what types of challenges? What did you do to overcome these challenges? Who helped you?
When you think about your last delivery, is there anything you wish you would have done differently?

PART 4 SOCIAL AND FAMILY SUPPORT

INTRODUCTION AND TRANSITION
- **Now, I would like to ask some questions about social and family support**
- **Once again, I shall begin with a few yes-no questions. Please first just answer yes or no for each questions, then we will have a chance to chat about things in more detail**

		Yes (1)	No (2)
SFS1	In the first few weeks after delivery, was your family supportive?		
SFS2	In the first few weeks after delivery, did you ever feel afraid?		
SFS3	Do you think service providers at hospitals offer good advice?		
SFS4	Do you think service providers at hospitals explain things well?		
SFS5	Do you think service providers at hospitals treat women with respect during pregnancy and delivery?		
SFS6	Do your family members offer good advice regarding your health?		
SFS7	Do your family members ever make it hard for you to be a good mother?		

TRANSITION
- **Great. Thanks for those responses**
- **Now I would like to speak in more detail about social and family support, and your experiences**

Do you feel like your family supports you in trying to be healthy, and to be a good mother? [Find out how]

Possible Probes
Are there ever instances where you get conflicting suggestions about your own health?
How do you make decisions when this happens?

Do you feel strong and confident to ask health service providers questions?

Possible Probes
If you have asked questions, what has that experience been like?
Are there any things about a hospital that scare you, or confuse you?

In your community, how is a woman treated after child birth?

Possible Probes
What are the expectations for women following birth? When do women go back to work?

Can you think of some of the NGO or donor projects specific to MCH in this community?

Possible Probes
What are some of the things they have done that have worked?
What are some of the things they have done that have not worked?

What do think is needed from the government to improve the services to ensure that women can be healthy during pregnancy and delivery? What stops these improvements from happening?

What advice do you have for women concerning marriage, pregnancy, and delivery?

- **That's the last set of questions I have. Thank you for time.**
- **I really appreciate your willingness to participate in this study.**
- **What you have told me has been very helpful. Thank you again**

Appendix Table 2 NVivo codebook

	NODE THEMES	NUMBER OF CODES
01	AHC – ABOUT HEALTH CARE	10
02	DLV – DELIVERY IN GENERAL	9
03	FDLV – FACILITY DELIVERY	9
04	NFDLV – NON-FACILITY DELIVERY	5
05	PRG – PREGNANCY	5
06	SFS – SOCIAL AND FAMILY SUPPORT	14
07	ZZZ – OVERARCHING CODES	22
	TOTAL CODES ACROSS CODE FAMILIES	74

Appendix Table 2—*Continued*

AHC – ABOUT HEALTH CARE		
1	AHC – attitude and general beliefs	Do what, go where when sick, and why. Including motivations, ways of thinking
2	AHC – description, health care facilities	Physical condition, quality of services, about equipment, problems, people, etc.
3	AHC – description, non-health care facilities	Use of herbs, alternative medicines. Anything health, but non-facility
4	AHC – experience, health care facility	Services sought, how treated, quality of care, and overall feelings about facility
5	AHC – experience, non-health care facility	Including use of herbs and other alternative medicines
6	AHC – improvements for health care	Services, equipment, supplies, staffing, facilities that could be better
7	AHC – most important women's health matters	Including, specific issue, disease, certain points in time being important
8	AHC – options for health care	Including what's most common, what people think and do, feelings on options
9	AHC – extra general health care code	Catch all code, useful for cross-coding
10	AHC – zing!	A really good quote about health care
DLV – DELIVERY IN GENERAL		
1	DLV – birth plan	Including health care and logistics associated with delivery location
2	DLV – ideal place for delivery	Where is best and why
3	DLV – important to avoid with delivery	In relation to health care, food, work
4	DLV – important to do with delivery	Including aspects of care-seeking
5	DLV – options for delivery	Including adequacy of options, feelings about options
6	DLV – regrets regarding delivery	In relation to services, decisions, etc.
7	DLV – who present/not present at delivery	Including family, service providers
8	DLV – extra general delivery code	Catch all code, useful for cross-coding
9	DLV – zing!	A really good quote about delivery

Appendix Table 2—*Continued*

FDLV – FACILITY DELIVERY		
1	FDLV – advocates of facility delivery	People that push to deliver at facility and/or are critical of home delivery
2	FDLV – experience with facility delivery	Description of experience delivering at a facility, including process and treatment
3	FDLV – SBA (views about, experience with)	Including how treated
4	FDLV – tensions regarding facility delivery	About services, advocacy, challenges, etc.
5	FDLV – zing!	A really good quote about facility delivery
NFDLV – NON-FACILITY DELIVERY		
1	NFDLV – advocates of non-facility delivery	People that push to deliver outside a facility and/or don't think facility needed
2	NFDLV – experience with non-facility delivery	Description of experience delivering at home (non-facility)
3	NFDLV – TBA (views about, experience with)	Including how treated
4	FDLV – tensions regarding non-facility delivery	About services, advocacy, challenges, etc.
5	NFDLV – zing!	A really good quote non-facility delivery
PRG – PREGNANCY		
1	PRG – ANC visits, number	How many times went for ANC, including 0 times
2	PRG – ANC visits, why and experience	Including reason for attending (or not attending) ANC
3	PRG – experience with pregnancy	Any mention of experiences about pregnancy health care both facility and non-facility based
4	PRG – feelings during last pregnancy	Including both positive and negative feelings, and if unplanned
5	PRG – important to avoid when pregnant	In relation to health care, food, work
6	PRG – important to do when pregnant	Including aspects of care-seeking
7	PRG – options during pregnancy	Including what's most common, what people think and do, feelings on options
8	PRG – extra general pregnancy code	Catch all code, useful for cross-coding
9	PRG – zing!	A really good quote about pregnancy

Appendix Table 2—*Continued*

SOCIAL AND FAMILY SUPPORT		
1	SFS – advice for other women	What the participant suggests that other women should/should not do
2	SFS – ask health service providers questions	Ability and experience
3	SFS – CHV, their influence and role	In relation to health care, pregnancy, delivery. How they advocate
4	SFS – expectations and practices post-birth	For women, men, families
5	SFS – family support	Positive support and lack of support
6	SFS – family views	Ideas, opinions, advocacy
7	SFS – MCH, role of government activities	Including views, insights, experiences, and awareness of free campaigns
8	SFS – MCH, role of non-government activities	Including private hospital, NGO, etc. Awareness of and involvement in
9	SFS – social or community support	Mention of support received from people other than families or CHV
10	SFS – social or community tensions	In general and in relation to health care, pregnancy, delivery
11	SFS – suggestions, bad or conflicting	Examples and navigations relating to health care, pregnancy, delivery
12	SFS – suggestions, good or helpful	In relation to health care, pregnancy, delivery
13	SFS – treatment of women after childbirth	By family and/or community
14	SFS – zing!	A really good quote about social and family support
ZZZ – OVERARCHING CODES		
1	ZZZ – accessibility, roads, transport	Cross code health care, pregnancy, delivery
2	ZZZ – cultural belief or practice	Including religious beliefs and taboos. Cross code health care, pregnancy, delivery
3	ZZZ – decision influencer	Person, organization, institution, event, etc. Cross code health care, pregnancy, delivery
4	ZZZ – economic issues	Cross code health care, pregnancy, delivery
5	ZZZ – examples of a challenge	Cross code health care, pregnancy, delivery
6	ZZZ – examples of overcoming a challenge	Cross code health care, pregnancy, delivery
7	ZZZ – female circumcision	Mention of, experience, beliefs about

Appendix Table 2—*Continued*

ZZZ – OVERARCHING CODES		
8	ZZZ – gender	Examples equity or inequity. Cross code health care, pregnancy, delivery
9	ZZZ – HIV in general	Any mention of HIV in general
10	ZZZ – HIV testing	Experience with and that testing part of ANC
11	ZZZ – hospital, bad things	Including scary or confusing
12	ZZZ – hospital, good things	In relation to services, equipment, supplies, staffing, facilities, etc.
13	ZZZ – level of understanding	Knowledge, awareness. Cross code health care, pregnancy, delivery
14	ZZZ – non-hospital, bad things	Including scary or confusing
15	ZZZ – non-hospital, good things	In relation to services, equipment, supplies, staffing, facilities, etc.
16	ZZZ – perceived risks	Cross code health care, pregnancy, delivery
17	ZZZ – reproductive health, family planning, birth control	Any mention of, and beliefs, practices
18	ZZZ – shame and/or stigma	Cross code health care, pregnancy, delivery
19	ZZZ – strike, shutdown, inefficiency	In relation to government
20	ZZZ – treatment of women	Cross code health care, pregnancy, delivery
21	ZZZ – tribes	Differences or comparing practices
22	ZZZ - zing! From KII	Great insights or quotes from KII that hard to capture with other codes

Appendix Table 3.1 Characteristics of the in-depth interview participants

Characteristic	All Participants		Peri-Urban Participants		Rural Participants	
	Response	N	Response	N	Response	N
Distance to nearest health facility from household in kilometers (mean)	3.0	57	2.6	28	3.4	29
Women's age in years (mean)	30.3	60	30.2	30	29.4	20
Women's age at marriage in years (mean)	19.6	57	19.4	20	19.9	28
Women's marital status (%) (N = 60)						
Married or partnered	91.7	55	90.0	27	93.3	28
Single	3.3	2	3.3	1	3.3	1
Widow	1.7	1	3.3	1	0.0	0
Divorced	1.7	1	0.0	0	3.3	1
Other	1.7	1	3.3	1	0.0	0
Women's primary occupation (%) (N = 58)						
Farmer	44.8	26	41.4	12	48.3	14
Business, retail, vending	20.7	12	31.0	9	10.3	3
Casual work, laborer	5.2	3	0.0	0	10.3	3
Housewife	22.4	13	20.7	6	24.1	7
Other	6.9	4	6.9	2	6.9	2
Husband's or partner's occupation (%) (N = 53)						
Farmer	37.7	20	30.8	8	44.4	12
Business, retail, vending	15.1	8	23.1	6	7.4	2
Casual work, laborer	5.7	3	0.0	0	11.1	3
Mechanic, electrician, masonry, miner	11.3	6	11.5	3	11.1	3
Health service, health care facility, pharmacy	7.6	4	0.0	0	14.8	4
Other	22.6	12	34.6	9	11.1	3
Religion (%) (N = 60)						
Christian	98.3	59	96.7	29	100.0	30
None	1.7	1	3.3	1	0.0	0
Tribe (%) (N = 60)						
Kikuyu	10.0	6	20.0	6	0.0	0
Luhya	1.7	1	3.3	1	0.0	0
Kalenjin	13.3	8	3.3	1	23.3	7
Luo	30.0	18	30.0	9	30.0	9
Kamba	1.7	1	0.0	0	3.3	1
Kisii	3.3	2	3.3	1	3.3	1
Turkana	18.3	11	20.0	6	16.7	5
Massai	1.7	1	3.3	1	0.0	0
Samburu	16.7	10	16.7	5	16.7	5
Other	3.3	2	0.0	0	6.7	2

Appendix Table 3.1—*Continued*

Characteristic	All Participants		Peri-Urban Participants		Rural Participants	
	Response	N	Response	N	Response	N
Women's level of education reached (%) (N = 60)						
None	25.0	15	23.3	7	26.7	8
Primary school	46.7	28	50.0	15	43.3	13
Secondary school	25.0	15	23.3	7	26.7	8
College or university	3.3	2	3.3	1	3.3	1
Number of family members living in house (mean)	6.9	60	7.4	30	6.4	30
Time lived in house in years (mean)	7.4	59	8.3	30	6.5	29
Head of household in relation to participant (%) (N = 60)						
Father	1.7	1	3.3	1	0.0	0
Husband	81.7	49	83.3	2.5	80.0	24
Wife	1.7	1	3.3	1	0.0	0
Father-in-law	5.0	3	3.3	1	6.7	2
Participant is head of household	8.3	5	6.7	2	10.0	3
Other	1.7	1	0.0	0	3.3	1
Number of times pregnant (mean)	4.4	60	4.9	30	3.9	30
Number of living children (mean)	4.2	60	4.6	30	3.7	30
ANC visits with last pregnancy (%) (N = 60)						
0 Visits	10.0	6	13.3	4	6.7	2
1 Visit	10.0	6	3.3	1	16.7	5
2 Visits	10.0	6	10.0	3	10.0	3
3 Visits	11.7	7	13.3	4	10.0	3
4 Visits	43.3	20	53.3	16	33.3	10
4 + Visits	15.0	15	6.7	2	23.3	7
Place of last delivery (%) (N = 59)						
Home	49.2	29	46.7	14	51.7	15
Public Hospital	40.7	24	43.3	13	37.9	11
Private Hospital	5.1	3	6.7	2	3.5	1
Missionary Hospital	5.1	3	3.3	1	6.9	2
During your last pregnancy at what point in time were you thinking most about place of delivery? (%) (N = 54)						
Months 1-3	14.8	8	14.8	4	14.8	4
Months 4-6	27.8	15	29.6	8	25.9	7
Months 7-9	22.2	12	14.8	4	29.6	8
All 9 Months	25.9	14	29.6	8	22.2	6
Did not think about it	9.3	5	11.1	3	7.4	2

Appendix Table 3.2 Tribe reported by in-depth interview participants by county

	Baringo	Kisumu	Migori	Nakuru	Samburu	Turkana	Total
Kikuyu	5	0	0	1	0	0	6
Luhya	0	1	0	0	0	0	1
Kalenjin	4	0	0	4	0	0	8
Luo	0	9	9	0	0	0	18
Kamba	1	0	0	0	0	0	1
Kisii	0	0	1	1	0	0	2
Turkana	0	0	0	1	0	10	11
Maasai	0	0	0	1	0	0	1
Samburu	0	0	0	0	10	0	10
Other	0	0	0	2	0	0	2
Total	**10**	**10**	**10**	**10**	**10**	**10**	**60**

Appendix Table 3.3 Place of last delivery by level of education reached for in-depth interview participants

	Level of education reached				
	Total	None	Primary	Secondary	College or University
Place of last delivery					
Home	29	12	16	1	0
Public Hospital	20	3	6	10	1
Private Hospital	3	0	2	0	1
Missionary Hospital	2	0	1	10	0
Total	**54**	**15**	**25**	**21**	**2**

Appendix Table 4.1 General perceptions regarding health services

In-Depth Interviews	% Yes	% No	N	Key Informant Interviews	% Yes	% No	N
Do you think sufficient hospitals exist in this community?	35.0	65.0	60	Do you think there are sufficient hospitals in this community?	34.8	65.2	23
Do you think hospitals are easily accessible in this community?	63.3	36.7	60	Do you think hospitals in this community are easily accessible?	45.5	54.5	22
Do you think hospitals in this community provide good services?	75.0	25.0	60	Do you think hospitals in this community provide good services?	95.8	4.2	24
Do you trust service providers at hospitals?	78.0	22.0	59	Do you think women in this community trust services providers at hospitals?	95.8	4.2	24
Have you ever felt afraid about going to a hospital?	26.3	73.7	57	Do you think women in this community ever feel afraid about going to a hospital?	45.8	54.2	24
Has anyone ever discouraged you from going to a hospital?	20.3	79.7	59	Do you think anyone discourages women in this community from going to a hospital?	16.7	83.3	24
Has anyone ever encouraged you to go to a hospital?	86.4	13.6	59	Do you think anyone encourages women in this community to go to a hospital?	78.3	21.7	23
Do you think women in this community commonly go to a hospital for treatment?	82.5	17.5	57	Do you think women in this community commonly seek health care services in hospitals?	95.5	4.5	22
Do you think women in this community commonly seek treatment outside a hospital?	48.2	51.8	56	Do you think women in this community commonly seek health care services outside a hospital?	31.8	68.2	22

Appendix Table 4.2 General perceptions regarding pregnancy

In-Depth Interviews	% Yes	% No	N	Key Informant Interviews	% Yes	% No	N
While pregnant, at any point was your family supportive?	82.8	17.2	58	While pregnant, do you think there are times the family is supportive of the expectant mother?	87.5	12.5	24
While pregnant, at any point was your family not supportive?	19.6	80.4	56	While pregnant, do you think there are times a family is not supportive of the expectant mother? (N = 24)	43.5	56.5	24
While pregnant, at any point did you feel afraid?	58.3	41.7	60	Do you think women in this community ever feel afraid during pregnancy?	56.5	43.5	23
While pregnant, did anyone discourage you from going to a hospital?	20.3	79.7	59	Do you think anyone discourages women in this community from going to a hospital during pregnancy?	13.0	87.0	24
While pregnant, did anyone encourage you to go to a hospital?	78.3	21.7	60	Do you think anyone encourages women in this community to go to a hospital during pregnancy?	95.7	4.3	24
While pregnant, were you involved in the decision whether or not to go to a hospital?	84.5	15.5	58	Do you think women in this community are involved in the decision whether or not to go to a hospital during pregnancy?	86.4	13.6	23
During pregnancy, do you feel a mother's life could be at risk?	82.5	17.5	57	Do you think women in this community feel a mother's life is at risk during pregnancy or delivery?	87.5	12.5	24
During pregnancy, do you feel the baby's life could be at risk?	63.2	36.8	57	Do you think women in this community feel a baby's life is at risk during pregnancy or delivery?	91.7	8.3	24
Do you have any regrets about decisions you made with past pregnancies?	31.6	68.4	57	Do you think women in this community have any regrets about the decisions they have made with past pregnancies?	58.3	41.7	24

Appendix Table 4.3 General perceptions regarding delivery

In-Depth Interviews	% Yes	% No	N	Key Informant Interviews	% Yes	% No	N
Do you think a hospital is a good option for delivery?	95.0	5.0	60	Do you think women in this community feel a hospital is a good option for delivery?	91.3	8.7	23
Do you think a hospital is the only good option for delivery?	89.8	10.2	59	Do you think women in this community feel a hospital is the only good option for delivery?	63.6	36.4	22
Do you think most women in this community deliver in hospitals?	69.5	30.5	59	Do you think most women in this community deliver in hospitals?	73.9	26.1	23
Did the location of the hospital influence your decision about where to deliver?	67.2	32.8	58	Do you think the location of the hospital influences the decisions women make about where to deliver?	65.2	34.8	23
Did the type of hospital influence your decision about where to deliver?	54.2	45.8	59	Do you think the type of service providers at a hospital influence the decisions women made about where to deliver?	86.4	13.6	22
Do you think hospital staff discourage delivery outside of a hospital?	81.7	18.3	60	Do you think health care facility workers in this community discourage delivery outside a hospital?	91.3	8.7	23
Do you think people in this community discourage delivery at a hospital?	5.1	94.9	59	Do you think people in this community discourage delivery at hospital?	21.7	78.3	23
Do you have any regrets about decisions you have made with past deliveries?	33.9	66.1	59	Do you think women in this community have any regrets about the decisions they have made with past deliveries?	59.1	40.1	22

Appendix Table 4.4 General perceptions regarding social and family support

In-Depth Interviews	% Yes	% No	N	Key Informant Interviews	% Yes	% No	N
In the first few weeks after delivery, was your family supportive?	88.1	11.9	59	In the first few weeks after delivery, do you think women in this community feel that their family is supportive?	91.3	8.7	23
In the first few weeks after delivery, did you ever feel afraid?	35.0	65.0	60	In the first few weeks after delivery, do you think women in this community ever feel afraid?	19.0	81.0	21
Do you think service providers at hospitals offer good advice?	98.3	1.7	58	Do you think women in this community feel that service providers at health care facilities offer good advice?	100	0.0	23
Do you think service providers at hospitals explain things well?	98.3	1.7	59	Do you think women in this community feel that service providers at health care facilities explain things well?	100	0.0	23
Do you think service providers at hospitals treat women with respect during pregnancy and delivery?	76.3	23.7	59	Do you think services providers at hospitals treat women with respect during pregnancy and delivery?	95.7	4.3	23
Do your family members offer good advice regarding your health?	89.7	10.3	58	Do you think women in this community feel that their family members offer good advice regarding their health?	90.9	9.1	22
Do your family members ever make it hard for you to be a good mother?	27.1	72.9	59	Do you think women in this community feel that their family members ever make it hard for them to be a good mother?	50.0	50.0	22

Appendix Table 5.1 General perceptions regarding health services by last place of delivery

	Place of Last Delivery = Home			Place of Last Delivery = Facility		
	% Yes	% No	N	% Yes	% No	N
Do you think sufficient hospitals exist in this community?	24.1	75.9	29	43.3	56.7	30
Do you think hospitals are easily accessible in this community?	51.7	48.3	29	73.3	26.7	30
Do you think hospitals in this community provide good services?	65.5	34.5	29	83.3	16.7	30
Do you trust service providers at hospitals?	75.9	24.1	29	79.3	20.7	29
Have you ever felt afraid about going to a hospital?	29.6	70.4	27	24.1	75.9	29
Has anyone ever discouraged you from going to a hospital?	20.7	79.3	29	20.7	76.3	29
Has anyone ever encouraged you to go to a hospital?	78.6	21.4	28	96.7	3.3	30
Do you think women in this community commonly go to a hospital for treatment?	78.6	21.4	28	85.7	14.3	28
Do you think women in this community commonly seek treatment outside a hospital?	46.4	53.6	28	51.9	48.1	27

Appendix Table 5.2 General perceptions regarding pregnancy by last place of delivery

	Place of Last Delivery = Home			Place of Last Delivery = Facility		
	% Yes	% No	N	% Yes	% No	N
While pregnant, at any point was your family supportive?	78.6	21.4	28	86.2	13.8	29
While pregnant, at any point was your family not supportive?	22.2	77.8	27	17.9	82.1	28
While pregnant, at any point did you feel afraid?	62.1	37.9	29	56.7	43.3	30
While pregnant, did anyone discourage you from going to a hospital?	27.6	72.4	29	13.8	86.2	29
While pregnant, did anyone encourage you to go to a hospital?	79.3	20.7	29	80.0	20.0	30
While pregnant, were you involved in the decision whether or not to go to a hospital?	89.3	10.7	28	79.3	20.7	29
During pregnancy, do you feel a mother's life could be at risk?	92.9	7.1	28	71.4	28.6	28
During pregnancy, do you feel the baby's life could be at risk?	75.0	25.0	28	50.0	50 .0	28
Do you have any regrets about decisions you made with past pregnancies?	40.7	59.3	27	20.7	79.3	29

Appendix Table 5.3 General perceptions regarding delivery by last place of delivery

	Place of Last Delivery = Home			Place of Last Delivery = Facility		
	% Yes	% No	N	% Yes	% No	N
Do you think a hospital is a good option for delivery?	89.7	10.3	29	100	0.0	30
Do you think a hospital is the only good option for delivery?	82.1	17.9	28	96.7	3.3	30
Do you think most women in this community deliver in hospitals?	53.6	46.4	28	83.3	16.7	30
Did the location of the hospital influence your decision about where to deliver?	85.7	14.3	28	48.3	51.7	29
Did the type of hospital influence your decision about where to deliver?	60.7	39.3	28	50.0	50.0	30
Do you think hospital staff discourage delivery outside of a hospital?	79.3	20.7	29	83.3	16.7	30
Do you think people in this community discourage delivery at a hospital?	3.4	96.6	29	6.9	93.1	29
Do you have any regrets about decisions you have made with past deliveries?	46.4	53.6	28	20.0	80.0	30

Appendix Table 5.4 General perceptions regarding social and family support by last place of delivery

	Place of Last Delivery = Home			Place of Last Delivery = Facility		
	% Yes	% No	N	% Yes	% No	N
In the first few weeks after delivery, was your family supportive?	78.6	21.4	28	96.7	3.3	30
In the first few weeks after delivery, did you ever feel afraid?	31.0	69.0	29	40.0	60.0	30
Do you think service providers at hospitals offer good advice?	100.0	0.0	27	96.7	3.3	30
Do you think service providers at hospitals explain things well?	96.6	3.4	29	100.0	0.0	29
Do you think service providers at hospitals treat women with respect during pregnancy and delivery?	65.5	34.5	29	86.2	13.8	29
Do your family members offer good advice regarding your health?	82.1	17.9	28	96.6	3.4	29
Do your family members ever make it hard for you to be a good mother?	35.7	64.3	28	20.0	80.0	30

Appendix Table 6 Selected Kenya Master Health Facility List data for the six counties selected for the study

Sub County		Population	Population Density	# of Facilities (per level)					# of wards
				Level 1	Level 2	Level 3	Level 4	Total	
1	Baringo Central			0	32	7	1	40	5
2	Baringo North			0	45	1	0	46	4
3	Marigot			0	23	3	1	27	4
4	Koibatek			0	29	5	2	36	6
5	Mogotio			0	28	4	0	32	3
6	Tiaty			0	23	5	0	28	7
Baringo County		**555,561**	**50 / km²**	**0**	**180**	**25**	**4**	**209**	**29**
1	Kisumu Central			0	43	7	8	59	6
2	Kisumu East			0	19	7	1	27	4
3	Kisumu West			0	16	6	5	27	5
4	Muhoroni			0	21	10	2	33	5
5	Nyakach			0	20	6	2	28	5
6	Nyando			0	16	10	2	28	5
7	Seme			0	20	3	2	24	4
Kisumu County		**968,909**	**460 / km²**	**0**	**155**	**49**	**22**	**226**	**34**
1	Awendo			0	23	3	1	27	4
2	Kuria East			0	18	6	2	26	5
3	Kuria West			0	34	11	2	47	7
4	Nyatike			0	33	4	2	39	6
5	Rongo			0	15	4	1	20	4
6	Suna East			0	14	2	1	17	4
7	Suna West			0	18	5	2	25	4
8	Uriri			0	18	3	1	22	5
Migori County		**917,170**	**355 / km²**	**0**	**173**	**38**	**12**	**223**	**39**
1	Nakuru North			0	37	8	1	45	5
2	Gilgil			0	38	4	3	46	5
3	Kuresoi North			0	22	3	0	25	4
4	Kuresoi South			0	25	3	0	28	4
5	Molo			0	19	1	2	22	4
6	Navasha			0	50	14	6	70	8
7	Nakuru East			0	55	6	7	82	6
8	Nakuru West			0	35	5	6	32	5
9	Njoro			0	36	7	0	43	6
10	Rongai			0	31	3	0	34	5
11	Subukia			0	18	6	0	24	3
Nakuru County		**1,603,325**	**213 / km²**	**0**	**366**	**60**	**25**	**451**	**55**
1	Samburu Central			0	28	2	0	30	5
2	Samburu East			0	17	2	1	20	4
3	Samburu North			0	20	1	1	22	6
Samburu County		**223,947**	**11 / km²**	**0**	**65**	**5**	**2**	**72**	**15**
1	Loima			0	21	4	1	26	4
2	Turkana Central			0	56	2	1	59	5
3	Turkana East			0	15	4	1	20	3
4	Turkana North			0	32	3	1	36	6
5	Turkana South			0	27	2	1	31	5
6	Turkana West			0	37	3	2	44	7
Turkana County		**855,399**	**12 / km²**	**0**	**188**	**18**	**4**	**216**	**30**
		5,124,311		***0***	***1,127***	***195***	***75***	***1,397***	***202***