

Experiences of Childbirth by Women and their Care Providers in Narok and Isiolo Counties, Kenya



Coalition on Violence Against Women – Kenya
(COVAW-K)

&

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*Asanteni nyote!
Amimo Agola*

LIST OF ACRONYMS AND ABBREVIATIONS

ACK CCS	Anglican Church of Kenya, Christian Community Services of Mt. Kenya East, Isiolo Branch
ACK NIHP	Anglican Church of Kenya, Narok Integrated Health Programme
ANC	Antenatal Care
BEmOC	Basic Emergency Obstetric Care
CEmOC	Comprehensive Emergency Obstetric Care
CHW	Community Health Worker
CME	Continuing Medication Education
COVAW	Coalition on Violence Against Women - Kenya
CS	Caesarean Section
DHMT	District Health Management Team
DPHN	District of Public Health Nursing
FBO	Faith-Based Organisation
FGM/C	Female Genital Mutilation/Cutting
ICPD	International Conference on Population and Development
IDP	Internally Displaced Persons
MCH	Maternal and Child Health
MDG	Millennium Development Goal(s)
MNH	Maternal and Newborn Health
MOPHS	Ministry of Public Health
MOMS	Ministry of Medical Services
PNC	Postnatal Care
PPH	Post-partum haemorrhage
TBA	Traditional Birth Attendant
WHO	World Health Organisation

EXECUTIVE SUMMARY

Although Kenya is making tremendous headway in defining and implementing policies and strategies to address the burden of maternal ill-health, health indicators continue to indicate a lack of significant improvement. Furthermore, it appears that Kenya is faced with not achieving her national and international obligations, in terms of the Millennium Development Goals (among others) related to maternal health.

A gap identified in the general approach taken to addressing maternal health in Kenya is the considerable lack of interest and incorporation of the views of women/mothers themselves, as well as their caregivers, to help better direct and make more effective the policies and programmes that serve and involve them. The Coalition on Violence Against Women-Kenya have therefore commissioned this study to capture the perspectives of women and their care providers towards childbirth in the aim of further improving approaches and services for mothers.

To achieve this, this study made use of phenomenology methodology to gain insight into their experiences. The study was conducted in Narok and Isiolo Counties. Women and their caregivers were interviewed using semi-structured interviews and these were conducted in the respective District Hospitals, one highly remote, and one non-remote village, as well as with managers of community health programmes run by faith-based organisations.

A total of 20 and 18 interviews were conducted in Narok and Isiolo respectively. These were done with post-partum women, traditional birth attendants, community health workers, midwives, and health managers. The outcomes of the interviews were vast in scope and were hence grouped and reported upon under the following subjects: Antenatal care at a health facility or mobile outreach clinic; Antenatal care with a traditional birth attendant; Nutrition during pregnancy; Decision of where to give birth; Giving birth in a health facility; Giving birth at home; Postpartum/postnatal care; Male, family and community participation in maternal health; Community-based maternity health services; Socio-cultural issues; and maternal and newborn mortality.

This study reinforced just how complex the issues of maternal health are. The mothers and health professionals all emphasised just how deeply pregnancy and childbirth are inextricably linked to social constructs and dynamics. This came out particularly strongly in illustrating the diametrically opposed views of these stages of life from the women's and communities' perspectives, whereby they are viewed as normal, natural, and celebratory, and on the other side the health professionals who view them as 'illness and disease' needing to be managed.

Thus the findings stressed the need to further question, analyse and give due attention to the holistic nature and social determinants of maternal health. They also pointed to the need to commit to an approach or approaches which address empowerment, human-rights, and inequalities and not only to the technical/clinical

aspects in order to fast-track progress in attaining improved maternal health. Having said that, the technical/clinical aspects of maternal health still very much require attention, particularly in ensuring that policies and practices are evidence-based and up-to-date. All these continue to point to the facts that women's and maternal health remain deeply determined by power and politics and that our collective health and development futures are highly dependent on us making greater progress in meeting the needs of mothers and their families and communities throughout the country.

Coming out of this study, recommendations were made in the following areas:

- Human rights mainstreaming in maternal health;
- Galvanising political and multi-sectoral support for maternal health;
- Exploring and implementing innovative approaches to maternal health;
- Ensuring evidence-based and women-centred care strategies and practices; and
- Promoting male, family, and community participation in maternal health

INTRODUCTION

Health, wellbeing, equality, and the rights of women are clearly recognised as a central pillar and indicator of health, development and peace of any society. Despite Kenya's tremendous economic, developmental and health strides over the years however, inequality in health and mortality experienced by women remains unacceptably high. The bulk of this burden is as a result of pregnancy and childbirth which continue to carry high risks despite numerous national and international commitments towards address the factors fuelling this. In Kenya, approximately 14,700 women and girls die every year due to pregnancy-related complications with an additional 294,000 to 441,000 women and girls suffering debilitating health conditions as a result of pregnancy or childbirth¹. Conditions arising during the perinatal period[†] are the second leading cause of death and disabilities in Kenya at 9% of total deaths and 10.7% of total DALY's* respectively².

The root causes of this situation are clearly wide and deep. Indeed some key problems within the health sector such as inadequate numbers of skilled attendants, poorly-resourced health facilities, non-existent infrastructure, high user fees, low motivation of healthcare providers, etc., have been frequently cited and the Government of Kenya along with Development Partners continue to work towards addressing them. However, progress towards attaining the country's commitments particularly that of Millennium Development Goal (MDG) 5 - "Improve maternal health" - is abysmal, with no tangible progress having being made at all³. This makes it clear that a great deal still urgently remains to be done in both the

[†] World Health Organisation definition: from 22 weeks gestation to 7 completed days after birth

* Disability Adjusted Life Years - Time lost due to incapacity arising from ill health

“obvious” and targeted areas as well as in the “not so obvious” and neglected realms affecting maternal health and rights.

One of the imperative, yet “invisible” and un-emphasized areas affecting maternal health and rights is the whole “other side of the coin”, that of the demand side of health and health services; the perspectives of the women themselves. Although these are getting increasingly aired, there is very limited action and translation of these learnings into improved practices and policies.

For example, discussions held with women throughout the country for the Service Provision Assessment survey found that over one-fourth of focus groups cited stories of, and fear of “neglect, disrespect, abuse, beatings, and general mistreatment” during labour as the reasons for not having their babies in health facilities⁴. Furthermore, several studies conducted by national and international organisations with women from different sectors and demographic groups in various parts of Kenya have revealed devastatingly high incidences of poor clinical practices, discrimination, and deep and life-long physical and psychological wounds resulting from childbirth for many women, children and families^{5,6,7,8,9}. The latter were reported to have tremendously and directly impacted upon their long-term health, education, economic productivity, and general happiness in life.

Therefore, there is some evidence of concrete gaps and opportunities in maternal health requiring attention, yet they are not being given due emphasis. Addressing some of these issues would potentially widen the scope of impact of improving women’s health seeking behaviour and health outcomes (and that of their children). Moreover, it would raise to the fore some of the deeper, underlying, yet critical factors which absolutely must be addressed to ensure that universal health and basic human rights in Kenya are protected, respected, and promoted.

In a quest to further contribute towards tackling some of the remaining gaps in addressing maternal health and rights, the Coalition on Violence Against Women–Kenya (COVAW-K) commissioned this study. The aim of the study is to look into the experiences of childbirth by women and their care providers and identify concrete suggestions on how their positions can be incorporated into improving policies and practices to achieve greater impact on maternal health and rights, particularly in these regions.

This report outlines the methodology used for the study, followed by the findings, conclusions and resulting recommendations.

METHODOLOGY

This study used the methodological framework of phenomenology. Phenomenology enables one to understand individual or collective perspectives as she, he, or they experience and understand an event, feeling, relationship, programme, and/or issue, etc. In this particular study the phenomenon is “childbirth”.

The sites selected for this study were Narok and Isiolo Counties. These were conveniently sampled as the locations where collaborative programmes by COVAW-K and Christian Aid are being conducted. Within these locations, data collection was conducted in the District Hospitals and in one very remote, and one non-remote community. The criteria for selection of communities were: accessibility during the time of field visits (weather and security) as well being one of the sites for the outreach programmes run by Anglican Church of Kenya Christian Community Services of Mt. Kenya East, Isiolo Branch (ACK CCS) and Anglican Church of Kenya Narok Integrated Health Programme (ACK NIHP).

Data collection was conducted using semi-structured, in-depth interviews. The vast majority of interviews were conducted in Swahili except for those conducted with the health managers who were comfortable using English, and with some of the community members who didn't speak Swahili. For those community members who could only speak their native dialect, with the approval of the interviewee, the community health workers (CHW) assisted with translation. All interviews were digitally recorded. In addition, the study coordinator conducted informal discussions with various people and recorded relevant observations within the health settings as well as in the communities.

Verbal consent was obtained from all interviewees to participate in the study as well as for the interview to be recorded. Wherever photographs were taken, each individual or their parent/guardian, in the case of children, was requested permission first.

Swahili transcripts were translated into English. Note on the translation: the dialogue was translated as directly as possible. However, in some instances where the interviewee was struggling to find the appropriate technical term to describe the anatomy, physiology, or clinical procedure, the appropriate word was inserted to ease understanding. In line with phenomenological studies, to analyse the data “meaningful units” were extracted and linked to convey the themes and patterns that arose and exist.

FINDINGS

Settings

Narok County consists of four Districts: Narok North, Narok South, Transmara East, and Transmara West. The County has a population of 850,920. The population is mainly Maasai who are predominantly pastoralists and agro-pastoralists. Communities and villages are scattered throughout the County, making many extremely remote and highly difficult to access, particularly during the rainy season, even though the main road arteries are in very good condition.

The largest hospital in the County is Narok District Hospital which provides comprehensive emergency obstetric care (CEmOC). Apart from this hospital there are two other District hospitals and two mission hospitals that offer CEmOC. Other than these, there are 16 Health Centres and 84 Dispensaries that are all supposed to offer basic emergency obstetric care (BEmOC), although in reality shortages of supplies and staff often impedes this. Apart from health services offered by the Ministry of Public Health and Sanitation (MOPHS) and Ministry of Medical Services (MOMS), there are several non-governmental organisations (NGOs) and faith-based organisations (FBOs) operating in this region, including ACK NIHP. The latter offers health services both in static clinics as well as in community settings through their mobile outreach programme.¹⁰

Isiolo County on the other hand covers a much wider geographical area than Narok County, however, only has a population of 104,264. Communities are extremely sparsely distributed making access and communication very challenging, particularly as this is compounded by incredibly poor and non-existent road networks. Isiolo is inhabited by a wide range of ethnic groups, mainly Samburu, Turkana, Borana, and Somali.

There are only 20 public health facilities in the whole County: one District Hospital and the rest being Dispensaries. There are however a few Health Centres run by NGOs and FBOs. One of these is ACK CCS, which runs a clinic in the outskirts of Isiolo town as well as a mobile outreach clinic which operates in areas designated by the District Health Management Team (DHMT), including some of the remotest parts of the County.

Geographical access is a great barrier to uptake of health services, with the furthest Dispensary (Marti) being 292km away from the District Hospital. This is particularly critical when it comes to maternal health as is evident in the statistics that indicate that only approximately 40% of births are attended by a skilled attendant. Coverage of antenatal care (ANC) is significantly higher though at approximately 80%, whereas postnatal care (PNC) coverage is dramatically lower at only about 5%. The District Hospital is the only facility offering CEmOC and whenever these are not available, patients must be transferred to Meru District Hospital.¹¹

Interviews

A total of 38 interviews were conducted: 20 in Narok and 18 in Isiolo. A breakdown of the different people interviewed is provided in *Table 1* below. In Narok the interviews took place at: Narok District Hospital and the ACK NHIP mobile outreach clinic sites in Olenkulo village and Suswa town. In Isiolo the interviews were conducted in: Isiolo District Hospital, ACK CCS Health Clinic Isiolo, Gotu and Luwangira villages, and in Chumvi IDP camp. Due to the presence of significant numbers of internally displaced persons (IDP) in Isiolo, it was considered important to capture their unique perspectives as well.

All women who were selected for interviewing were those who had given birth within six months of the interview. The most prominent TBAs in the different communities were who were included in the study. The midwives were randomly selected from those who were on duty in the maternity wards on the day of visiting the District Hospitals. Health managers were interviewed both in the public health system as well as in the ACK programmes.

Table 1: Distribution of Interviews Conducted in Narok and Isiolo Counties

	Narok	Isiolo
Post-partum women	14	11
TBAs	2	3
CHWs	1	1
Midwives	1	1
Health managers	2	2 ¹
Total	20	18

Various themes arose during the interviews and they have been discussed independently below. The quotations used in this report are those which demonstrate the predominant or outlying views. Each quotation is from different people, however, these have been strung together to form somewhat of a narrative and to illustrate the themes.

Antenatal Care at Health Facilities or Mobile Outreach Clinics

As antenatal care (ANC) is an integral part of ensuring a safe and healthy pregnancy and birthing, discussions undoubtedly touched upon this. The vast majority of women attend ANC, with Isiolo reported coverage of as high as 80%¹². As a midwife said: “once they are pregnant they know they need to go to the clinic. We don’t have

^{#1} Including the District Health Management Team

to force them. This means they are informed about ANC." A mother in Isiolo confirmed this stating that "in fact all pregnant women will go [to ANC]".

It appeared though that most women begin their ANC visits well into their second trimesters and so manage only two to three visits. However, a midwife reported otherwise that the "majority do at least four; in fact those who are used to coming every month (as per the old system prior to focused ANC) ask "sister why have you given me such a far date?"".

"We hear in the market people saying that this place is good" for ANC according to one District Hospital midwife. "Maybe it is because of the new performance contracts. We no longer make them sit around for so long. We have to work according to what we have agreed with the government. This is guiding us and because of these we have improved a lot." Another health professional complemented that "having the services integrated really helps the mothers and provides some continuity of care".

However, uptake of ANC appeared to be highly dependent on distance to the clinic/hospital or presence of mobile outreach clinics within their communities. In most of their mobile outreach clinic locations both the ACK NIHP and ACK CCS programmes in Narok and Isiolo respectively had been experiencing a steady increase in numbers attending ANC with each successive visit. Unfortunately though in some of the communities in Isiolo it was remarked that women were no longer obtaining ANC since ACK CCS stopped visiting them due to resource cuts. This sadly was appearing to significantly affect the credibility of the organisation and their services.

Antenatal Care with a Traditional Birth Attendant (TBA)

Women also seek care from TBAs during their pregnancy. "Women tend to visit me from three months for assessment and a few more times during pregnancy if she has any problems." Another TBA claimed that women continue to "regularly visit me until they are ready to birth". The TBAs went on to share that "I begin to serve women when they are pregnant to help with the proper alignment of the babies as I believe proper alignment of the baby is the most important thing for a smooth birth." "I also advise pregnant women about their diet and what they should do and not do to take care of themselves and their babies to ensure a smooth birth." "For the women who haven't had a baby before, I explain to them when labour comes you will feel like this, like this, and like this and you should do this, and do this, and do this, so that they know."

Apart from general assessments and health education, most women and TBAs reported that the TBAs "assess the position that the baby is lying and try and turn the baby when it is not in a good position". "To do this we massage using oil." Moreover, they use massage "to heal whatever ailment they may be having, for

example pain, heartburn, etc.”. One TBA who had received training from an NGO was firmly against this though saying that “we were taught that trying to turn the baby can be very dangerous and hurt the baby, so when the baby isn’t lying properly I advise the mother to go to the hospital”.

Nutrition during Pregnancy

As a health manager in Narok pointed out, during pregnancy “nutritional status is a key issue”. Members of the community think likewise, with one TBA in Isiolo going as far as to admit that the outcome of the decision made to birth at home or at a health facility with a skilled attendant “depends on if you have food or not. If you haven’t got food then birthing can be a problem, whereas if you do, then it will go smoothly”. Having said that, although women and their families are conscious of eating well during pregnancy, doing so is particularly difficult for women as a health manager in Isiolo pointed out, “women and children are left with the burdens of living sedentary lives as the men move around with the livestock. Women aren’t permitted to slaughter animals while their husbands are away. Some make charcoal but are often arrested as it is illegal. Moreover, climate change has led to less and less farming being feasible”.

In addition to these challenges we learned that particularly in Narok but also a bit in Isiolo that “TBAs advise women not to eat much, particularly with their first child, so that baby is small and doesn’t complicate deliveries”. A mother in Isiolo also indicated that “this is because the baby will become too fat which isn’t good as the baby will have problems coming out”.

Decision of Where to Give Birth

There was a clear split in opinion on where women preferred to give birth with the reasons being quite varied. This was across the board in both Narok and Isiolo with a few exceptions observed. These exceptions were: that it was observed that the women who elected to come to the hospital had much higher education than the others interviewed; lived within the town or very close to the District Hospital, and/or were Somalis. Some of the sentiments of these women were: “you know I am not used to giving birth at home, if you are used to home you can never accept the hospital and if you are used to the hospital you can never agree to giving birth at home”. And another mother felt that “you know the placenta may refuse to come out, that is why hospital is better”. And yet another woman from Narok cited that “if you stay at home you could get sick”. These observations were confirmed by a midwife who said that “hospitals are simply for emergencies and those with complications or those who live nearby”.

However, apart from these influences of culture, of the TBA and community, of fear, of geographical access, of economic access, and of health status were reported to be

the other major factors behind women's decisions of where to birth. These are each discussed below.

Cultural Influences

There are deep cultural biases that influence the uptake of maternity services. For example, "Maasais generally birth at home, we don't often go to maternities"; "I didn't go or even consider going to the hospital as Maasai women do not like to go to hospitals as they believe that God will help them"; "we Turkana's just have our babies at home"; and "the Turkana like to give birth at home".

The perception of pregnancy and birthing being a very normal function and part of the cycle of life is very strong among these communities. A Maasai woman shared that "even now there are still many who birth at home. People have always been birthing at home throughout our history. People are yet to get confidence/trust in hospitals. Some people have, some people haven't." And a mother in Isiolo confidently said that "we don't go to hospital because we are used to birth at home. It is normal to birth at home." In relation to birthing in hospitals mothers felt that "I didn't think of going to the hospital because my friends all had their babies at home so I didn't wish to go to the hospital"; and "I don't know anyone who goes to the hospital, all birth at home. I don't know why this is. Maybe because home is better." All this was emphasised further by a Turkana mother living in an internally-displaced persons (IDP) camp in Isiolo who said: "now if one doesn't have a problem with their bodies, what are you going to the hospital to look for? If I am strong and healthy and birthing is normal, what's the problem right?"



Influence of the TBA and Community

TBAs and other members of the community wield a great deal of power and influence in determining women's health-seeking. Many of the TBAs feel that "here is just like there [the hospital], there aren't any problems"; "Giving birth at home isn't bad. If she is healthy and everything is going smoothly and we have everything here, we have clothes, we have everything, and we will support her here, then she will just birth here"; and "If the baby's God is bringing the baby well, then we will just support the woman here just like the other doctors do in the hospital." Interestingly, a TBA in Narok noted that she has observed that "women who birth smoothly and healthily at home have healthier babies/children".

TBAs are also of the opinion that "we have been also received training", be it over many years through apprenticeship, or by some NGO. "You know they teach us that when a woman is approaching her time to give birth that we should take her to the hospital. But because we are used to supporting women at home and we have been trained in that, with regards to the thread, the razor, gloves, and they say if a woman doesn't manage to get to hospital that we should use all these things."

However, one TBA believes that "if she [the woman] is feeling any strange pain or not feeling well then we send her to the doctors immediately. If nothing is wrong we know she will birth smoothly here at home". Apart from these cases, the TBAs consider "the babies who are coming feet first, or twins, and the like, they are all completely fine to give birth at home". Yet another one's position was that "we really encourage the women to go to hospital though. We tell them that the doctors are able to detect if there is anything wrong. Maybe you have low water or something and we here cannot measure that and maybe if you don't go to the hospital you can have even worse problems".

The recommendations and advice of a TBA are taken very seriously, demonstrated well by an example from a mother in Narok who recounted that "one of the women from the start was saying that I should be taken to the hospital because whenever I pushed, the baby moved to the side. But the others, who aren't doctors, they just said whenever I feel the baby coming I should push and when they said push, I pushed. But when this doctor said that, they listened. It had taken her some time to come though and tell these other women because she lived very far away and it took time for my sister to go and get her."

Influence of Fear

Fear of the unknown is a very common factor in women soon to give birth the world over. However, in Kenya and in these communities in particular fears of childbirth take on a whole new meaning. For instance according to one health manager, "the majority of them [Turkana], even the more learned ones, they fear coming to hospital." A community health worker (CHW) stressed that "they say because in hospital they are forced to give birth when they are not yet due, or push when they

are not ready to". "They also think and fear that they will be cut if they go to hospital." This latter fear is discussed in more detail below under *Procedures and Practices of Health Care Providers and Health Facilities*. One young mother shared with us though that "women say that if you have the strength to push your baby out, you should push your baby out. If you don't, then you will be a "dog". That is said to make you not feel fearful".

Another thing according to one mother which "scares and puts off people going to the hospital is that we also hear that the doctors there are very harsh and if you are fearful you can be beaten". And as a health manager pointed out "they say the nurses talk rudely to them, so when they transmit this message to others in their community this discourages them". A mother in Isiolo was of the opinion though that "you know many people say that doctors are bad, but I have never encountered that. You know one must be careful in hospitals. Even if you are in pain, you should not scream and make a lot of noise and bother the doctors. You just wait for them and wait until God brings your child. You see some people bother the doctors until they are forced to beat them and it is actually them bringing it upon themselves, it is not that the doctors are bad. I have heard many people saying that they were beaten in hospital, but most of the Cushites aren't beaten it is just the others because you know we strain ourselves even if the pain is great, we just persevere as we know that only God knows when He will bring the baby out. If you find a woman saying a doctor is bad it is she who is bothering the doctor. If you are a humble person then the doctor will help you. If you pretend and be arrogant and the doctor instructs you to do something and you say no even the doctor will get cross. If you go to them for help you must then follow their rules".

On the other hand most health professionals feel differently. A health manager declared that "it has been quoted all over the country that nurses are rude, especially in maternity, to be sincere on a sincere note, there are no nurses who would want to be harsh, but at times circumstances force you". Another midwife shared that "I don't support being harsh but at times you find that it just happens". (More related to this is expanded upon further in the section on *Human Resources*.) However, a health professional in Isiolo felt that "a training to sensitise health care providers on the need to treat women with respect and sensitively" was needed and yet another in Narok was of the opinion that what was necessary is for "actively shift[ing] the negative attitudes towards the service providers that has formed. If their perceptions change that they are treated with respect, as human beings, that they aren't just dirty, then they would want to deliver in hospitals".

Influence of Geographical Access

The barrier of geographical inaccessibility is a huge influencing factor in most lower-income countries, but particularly in rural areas such as the vast majority of Narok and Isiolo Counties.

As a health manager put it “most deliveries happen at home although that is not their wish. They are forced to do this because the setup, the infrastructure, everything is not working”. Another midwife stated that “the distance is one of the main reasons they don’t come with some living up to 40km away”. The common consensus of many women was that “even if they did want to access it, the District Hospital is just too far” and “I would have gone to have my second child in hospital too if it was closer, but because it is so far I decided just to have him at home”.

However, even though some health managers believe that “if the health facilities were closer to their communities they would be better able to access those health services”, some mothers still adamantly state that even “if there was a hospital nearby I still wouldn’t go”.

For some the actual distance isn’t that much of an impeding factor, but the mode of transportation is. One mother claimed that “I had to go there walking”, yet others said that “labour caught me at a bad time and I was unable to take myself to hospital at that time”, and “if the baby just comes suddenly when is there time to go to the hospital? And when it is at night and there is no transport?”.

Numerous suggestions were made by the health workers to address low uptake of maternity health services and most of them focused on addressing the impact of geographical inaccessibility. One suggestion made “that would make the greatest impact on maternal health in this region and if resources weren’t such a constraint, would be having a well-equipped mobile ambulance with all the equipment for deliveries, with a standby driver and nurse”.



Influence of Economic Access

Equally significant to the geographical access barriers to uptake of maternity health services, was reported to be economic barriers. “I chose not to go to the hospital to give birth because we don’t have the money. If we had the money I would have chosen to go to the hospital.” Another mother said that “I will have them [future children] at home because we don’t have the money for the hospital”. One mother speculated that “it is likely to cost KSh. 5 – 7,000”.

“My operation cost KSh. 4,500” claimed one mother and another one reported that “my husband had to take out KSh. 10,000 for transport, doctor’s fee, the bed, and everything”. To pay the huge expenses, “my husband had to sell a cow, borrow money, and other things in order to get the money”. And another mother shared that “we had to sell a cow. And of course when you sell a cow urgently like that you don’t get a fair price and it takes time. [In the meantime] I continue to lie in hospital and the bill continues to increase as I wait for my husband to return with the money”. The pressure on health service providers is even higher due to community member’s expectations of services worth such high value. One mother in Narok illustrated this by saying “after paying all that money you expect to come out completely healed”.

The patriarchy and inequality of all of these societies also significantly impacts upon access to financial resources and thus health services. As a TBA well pointed out “I advised her to go back to the hospital but she hasn’t gone yet because her husband is not home. How can she go back to the hospital if she has nothing? It is better to go to hospital, but how?”.

Influence of Health Status

The decision of where to give birth is also guided by current as well as previous health status, particularly the outcome of previous births. According to several women “a woman goes to the hospital if she experienced any difficulties in her previous labours or was transferred”. One TBA stated that “I don’t think that women who haven’t had any problems during their pregnancy or previous births would go to the hospital to birth. Only those who have experienced problems”. The mothers themselves said that “if my baby is normal then I will just push him out here in my house, but if the baby is not lying properly then I will go to the hospital”; “the only reason I came to birth in the hospital was because my previous birth was by caesarean section (CS)” and “my first child was birthed in hospital because she was “late” and I was advised to go by the TBA”.

However, despite, health warnings, some women don’t heed them like the example of a mother in Isiolo whose “doctor told me that I must give birth in hospital, but as I had never given birth in hospital, I didn’t go to the hospital when my labour begun”. Several women though had clear desires to go to hospital as a result of their previous positive experiences, such as one mother in Narok who said that “I would

have preferred to go to hospital as there is a lot of help in hospital. I know this because when I first went to hospital I hardly knew where I was or who I was, but then I got my strength back and you see I even managed to give birth by myself at home, so the medicines the hospital gave me really helped me". And another woman in Isiolo who confirmed that "with future children I would like to also go to the hospital because in hospital they give you medicines and assure you complete health, I know this from when I was transferred there last time".

The challenges of altering some of these perceptions and health-seeking behaviours though remain immense. In Narok "90% give birth at home" according to the health workers there and despite the support of "success stories" from rural areas, " I will go home and tell them about the services here, but you know they are all hard headed and they all say that they must give birth at home".

Giving Birth in a Health Facility

Facilities

In reality according to one health professional "dispensaries don't offer comprehensive services and often they are closed. Sometimes they are closed for two weeks when they go on leave or maybe they [the health professional] go for the weekend leaving on Thursday, and returning on Monday. In one instance the nurse in charge just locked up and left and returned after six months during which time there was no one to put there to run the services." With another health worker claiming that there are also "very few health centres and dispensaries that offer BEmOC". Sadly also one health manager reported that "there is one particular maternity unit that is huge, but mothers simply don't go there. I don't know why". This situation worsens when theatre facilities are out of services in the District Hospital and "we hear via our colleagues in the community that there are rumours going around because we don't have a theatre that people shouldn't bother going to Isiolo [District Hospital], and that if you do go there you will be taken to Meru". The consequences of even the limited CEmOC not being available are dire with one midwife revealing that "we lost a baby on the way [being transferred] and it was the second baby that the mother had lost".

"The atmosphere in the outreach clinic was not like a hospital, it was interactive, a community gathering, joyous, laughter, casual, which makes it inviting. A setting like that women would readily go to, if you encourage them to come "believes one care provider. A couple of midwives complement this by saying that these facilities must be an "environment where the mother feels appreciated, where she can interact with the service providers" and which provides "a safe, dignified space where they feel welcome to go and give birth".

Observations were made in both District Hospitals that tremendous effort had been made in communicating the Citizen's/Patient's Charter to clients. They were painted

on several walls, even at the main gate and entrance to the hospital. Furthermore there are a number of suggestion boxes placed strategically around the hospital and posters bearing the guidelines for making formal complaints and suggestions. However, as one midwife exclaimed “as much as they are written in black and white and distributed all over the place, the patients may not read them or fully understand what they mean.” Another midwife pointed out though that “we are putting up posters for the clients outlining their rights, although some are in English so not everyone is able to read them, but we plan to translate them into local languages”. All the more reason then as one health manager pointed out that “the responsibility lies equally with the health professionals and the clients, but considering that the health professionals are more educated and exposed than the mother and they also are in the position of power, it should actually be the health professional who provides the support and opens the door for dialogue and promotion of the patients’ rights”.

Another pressing issue that was raised by a few interviewees is the case of toilets. “As much as we talk to people about observing hygiene when they are in the hospital and home setup, most women currently fear hospital deliveries, especially normal deliveries because they imagine the toilet they will be using isn’t very clean” considers a health worker.

Supplies

Equipment and supplies is a great debilitating factor to health services delivery and “these sorts of things are also very demotivating” cited to one health manager. According to the Isiolo DHMT, “most facilities lack the most basic delivery packs” to conduct births with only the Health Centres and the District Hospital having them in stock”. “Very few facilities also have delivery beds”.

In Isiolo “we have an additional burden of work because the water here is very hard and it is destroying our equipment. We have to do episiotomies and CS’s but our instruments get blunt and we are unable to do them properly. Some of the time though is the quality of the instruments. We use them once then put them in *Jik* and the next time we try and use them they break. I have a whole pile of broken instruments.”

The lack of supplies and facilities are also quite a disincentive to women to use the services. For example a health manager was of the view that “we encourage women to take something warm to encourage milk flow and some of them are feeling cold immediately after the birth and in some facilities they simply don’t these to offer, or they don’t have enough”. Another common problem stressed by the midwives is the woman “isn’t accessing sanitary pads for her monthly periods and now she is in the hospital and she doesn’t know any other methods to use in that setting, so supplying of these types of things would make her feel more comfortable and more willing to come and stay in the hospital”. In addition, “some of the other supplies that they

need during their time in hospital, e.g., slippers, towels, basins, etc.” would also be beneficial.

Services

From the mothers who had utilised health facility services, there was overwhelming praise for their services, from “the service I received here wasn’t bad” to “the District Hospital is very good, they helped me a lot because they used their things to help me”. Other women reported that “in Isiolo they served us very promptly and helped us a lot. They removed the remaining dirt and I was given blood transfusion”.

Whereas the rumours of maternity services at health facilities were quite mixed. Some mothers claimed that “other women say birthing in hospital was nice”; and “they haven’t experienced any problems and when they return home your body is healed”. Whereas others “say it’s a horrible place. You birth on your own. There’s no one to hold you. Nobody to guide you and advise you on what to do.” A TBA in Isiolo though was of the opinion that “I think hospital is better as a woman is using her money wisely. You see here at home we don’t have the right conditions”. Despite these views, in Isiolo for example, according to the health managers “delivery is a problem, even though we see ANC coverage at 80% very few come to hospital to give birth”.

Referrals or transfers are a common and necessary practice in all health systems, but there are mixed reports on these in the two Counties visited. One of the mothers in the postnatal ward in Isiolo District Hospital had a very positive experience of being transferred, free of charge, from Marsabit District Hospital for specialist treatment. And yet another mother in Isiolo had been referred to Meru District Hospital due to lack of operating theatre facilities, but had to find the means to get herself to Meru. On the other hand, in Narok, one woman who had been in labour for days at home and had gone to the nearest Health Centre, where there too they were struggling to help her was unable to be transferred to the District Hospital despite the efforts of the Health Centre manager as the District Hospital would only send an ambulance if the family paid KSh. 4,000, which they couldn’t afford.

Health services continue to raise the alarm on high mortality rates and in Isiolo for example there have been a number of recent extraordinary meetings called to “put more pressure on the other health facilities in the County to ensure that the women are assessed before being sent on their way to us [District Hospital]. Most of the intra-uterine foetal deaths and pre-eclampsia cases have been from Marti (the furthest Health Centre from the District Hospital). Also the standards in the private clinics around should be raised to have ideal conditions and they should make referrals in time”.

MATERNITY~SERVICE CHARTER

SERVICES OFFERED	CLIENT'S REQUIREMENT	TIME	COST
ADMISSIONS	ANC CARD, ADMISSION FILE	5 MIN.	200/- ONLY
DELIVERIES; SVD C/S	COTTON WOOL, CONSENT	5/15 < 12 Hours C/S < 1 hour	1,850 /- 5,000 /-
NURSING SERVICES, DRESSINGS	~	15 MIN.	FREE
TREATMENT and COUNSELLING	ANC CARD	5 MIN.	FREE
ANC SERVICES	INFORMATION, ANC CARD	30 MIN.	FREE
POST NATAL CARE (PNC)	~	~	~
PMTCT	CONSENT, INFORMATION	5 MIN.	FREE
NURSERY SERVICES	~	5 MIN.	200/- PER DAY

Procedures and Practices of Health Care Providers and Health Facilities

One of the greatest critiques of birthing in health facilities, even by those who are staunch supporters of this is as one mother put it “you know you are actually on your own”. Another young mother added “for three-and-a-half hours I was all on my own. I felt.....I was just getting on with my pains, but I felt like they weren’t concerned about me. I felt like the pains were increasing and the baby was getting closer. I was there with other women and everyone is just getting on with their pains as everyone has their own problems so nobody is in a position to help the other. We were all lying next to each other with no curtains in between.” Yet another woman reported that “the nurses would come and check on me and leave”. One lady lamented that “I would prefer though if we could stay with someone because you never know what you will be like when you birth, only God knows. It would be good if you could stay with at least one person because you are weak and you can have someone to help you”. As a health manager pointed out “there is nothing worse than being left alone when you are terrified”. And this was confirmed by a young mother who recounted that “my mother and the TBA were not allowed to stay, they were told to go and wait outside for the report. And I was only 18 years old. I felt very bad. The doctors didn’t speak to me at all until the baby was close to coming”.

An additional issue of great concern and cause of stress for women – both those who have experienced the services and those who haven’t – is the performing of episiotomies. Although they are not routine procedures the midwives conduct quite a considerable number, causing it to be a significant topic of discussion, e.g., “I heard that women are cut open if you are fearful using scissors on the path for the baby to come out. That is what I hear.” What aggravates the situation is often that “they cut me and they didn’t tell me, they just cut me and they kept quiet. This angered me”. One health manager argued that “often service providers obtain consent from the mothers or her relatives for any eventuality. But for ‘minor’ procedures, such as

vaginal exams, episiotomies, and the like, they don't, they just do it, as these are part of the expectations, part of the things that are so obvious, that they don't need to". This position is supported by some mothers who think that "if the child is coming and the opening is too narrow you know the doctor has to cut there isn't any other way. Whether you are asked or not, or whether you say no, what's the point because at the end of the day it is you who will get hurt. You will just be forced to be cut".

Three mothers claimed though that for all procedures "they were given some information before they did whatever they were doing"; "they even explained to me that they were putting a needle in my hand for medicines and water"; and "they must explain to you everything they do before they do it because those doctors are good". Whereas this wasn't found to often be the case and interventions in general appeared to be highly common, especially insertion of intravenous canulae, intravenous drips, intravenous pitocin/oxytocin (to induce or augment labour), rupturing of the membrane, and conducting of vaginal examinations. There were several ethical issues registered with regard to these, such as, "they also put up some water (a drip), but didn't tell me what they were doing or why. I wasn't given a chance to agree or not because I wasn't asked"; "when the pain was proceeding, I was given water (a drip) which increased the pain even more"; and "before the doctor examined me from the inside he didn't ask me. In the hospital they are always putting their fingers inside the vaginas but at home they never do that". Indeed though all women who underwent caesarean sections admitted that they, their husbands or their mothers-in-law gave consent prior to the procedure being conducted.

Another significant issue raised by many women is the positions that they are forced to take during birthing in a health facility. The greatest grievance is "I was made to birth on my back". They argue that "in hospital you are made to lie on your back with your legs up and open and the doctor puts his fingers inside and he is a male doctor, and that doesn't feel good." And another mother admitted that "we don't know how to do that". During the early stages of labour though, there are reports of "I was asked to just sit on a chair outside the ANC"; and "I was moving around taking lots of different positions as I felt like as they left me alone". The attitude and response by care providers to 'alternative' positions for labour didn't appear very positive with a midwife citing "if she wants to squat, what about me the midwife", and another reporting that "we don't allow them to stand, these are the difficult clients".

The personal care and attention offered by the health workers in the facilities often leaves their clients wanting. A new mother claimed that "the doctors and nurses just standby as I'm having the baby. All they do is catch the baby when the baby comes out. Then they ask me how I am doing". Another reported that "they came to move me when they heard me screaming and shouting. This is what called them". And yet another woman had to "just massage myself, they don't hold and rub me in any way". And lastly another mother declared that "in the hospital I was just lying down, I wasn't being helped at all". This attention however appears to change once the

woman is in the second stage of labour as one mother reported very positively that “once I was moved to the delivery bed, I wasn’t left alone, and from there they helped me. I was feeling like pushing but was very tired. But they encouraged me to push. When I was caught by the pains they would rub my back. This was so much nicer than being left alone. They really helped me”.

One procedure that all the mothers praised very highly was the active management of the third stage of labour. As one woman in Isiolo shared “what was good about hospital is that immediately after having the baby they give you an injection and all the dirt comes out right there. Whereas here at home even three weeks later blood and dirt is still continuing. In the hospital it all came out immediately, I had no more when I came home.” One mother in Narok based a lot of her satisfaction with the services based on this saying that “the staff at the Health Centre treated me well and made me feel good because they took out all that dirt”.

Visiting Hours

The issue of visiting hours was raised by many mothers. Many of them complained that in hospitals “there is no allowance where by any time is visiting time, it is scheduled”. “Visiting hours are very restrictive, and if one can manage, you can go and visit your relatives at the gate.” This is recognised as particularly difficult for mothers and families by one care provider who observes that “in hospitals she may have encountered a complication so her hospital stay is longer and she may not have the opportunity to interact with her family much”. When discussed with the health managers they argued that the hospital didn’t “have the setup of privacy as they are in a general ward without partitions” and that “many people coming into the ward would increase the chances of infections”. They thought that “with privacy observed it is possible [to be more flexible about visiting hours]”. This will be discussed further below in *Male, Family, and Community Participation*.

Human Resources

Staff numbers is a huge problem in the health systems visited. As one health manager simply put it, “we don’t have many health workers” and another that “staff shortage is a major, major issue”. A midwife claimed that “the labour room is supposed to have one nurse to one mother, but you find one nurse to five mothers.” Another midwife gave the example where “there are times when there aren’t even enough staff for the newborn unit and it has to be covered by staff from the postnatal. So sometimes all attentions are being diverted from postnatal and newborn units all to labour ward where the emergencies may be”. Moreover, according to a health manager “these staff shortages also put a great strain between colleagues”.

Pure numbers of health professionals though is not sufficient if they are not of the right calibre and specialisation. One mother who was transferred to Isiolo shared that

“the services in Marsabit Hospital are good, but they don’t have specialists, which is why we had to come here”.

The quantity of health professionals obviously impacts upon the quality of services. One health manager recounted a story of “I know of a nurse that on her own attended 13 normal deliveries and prepared four women for CSs in the course of a single night. What do you think will be the first words to you in the morning or when you point out an error? Often they feel like you only see mistakes not all the work they’ve done”. Another midwife recounted that “a health worker may have five labouring women at the same time and you can imagine how hectic it is and she doesn’t have the time to rub their backs, wipe their beads of sweat, encourage them, talk to them, it becomes an issue”. A midwife in Narok said that “she [a mother] asks you to stay with her and as much as you would like to you can’t as there are other labouring women you have to attend to. And if the nurse gets held up somewhere, she feels neglected”. Another midwife in Isiolo lamented that “the care we used to give to mothers and babies was of greater quality, but now we can’t due to the shortages of staff. I also do suffer psychologically, I feel so bad, because I want to give the best but I can’t because already I am tired and you know that being tired gives you a don’t care attitude....I don’t know....you see, so how can we focus on the care we are supposed to give to the patients?”.

Not only are the procedural expectations lacking, but this also impacts upon ethical requirements of the health workers too. As one nurse put it, “maybe what most health workers are missing is the issue of not telling her what is happening and they just say let me wait until the baby’s head is crowning then I will go and be with her and yet the stage of where to monitor in between and the time to explain everything to her has been missed out”. Another midwife recognised that “we are supposed to do it, but we just don’t do it”.

Through all of this “you find that the patients don’t understand the nurses, the doctors don’t understand the nurses. We are very strained and unable to do things to the timeliness of other people” was the view of one midwife. Another one gave a long example, but which captures this well: “there can be a woman who needs to be prepared for theatre and at the same time there are two other mothers screaming ‘sister I feel like pushing’ of course I am not going to prepare the woman for theatre. You pick the baby first and the other one has to wait a little bit. And you find sometimes the doctors are complaining that you are taking too long. Whereas during that time you helped receive a baby, maybe the mother developed PPH (post-partum haemorrhage), you had to attend to her and you had to attend to the baby who maybe had difficulties too. So you find in these circumstances where a nurse is overstrained when you meet her outside and a patient says all morning you haven’t given me permission, and she has just come from being shouted at in theatre, and before that troubling with a patient, and the nurse may not be able to tell the doctor 1, 2, 3, because the doctor or anaesthetist only sees that their time has been wasted and this is an emergency, and now this other client is upset because you haven’t seen to them and now, you haven’t even taken any tea you have been moving up and

about, up and about, as a human being you may not answer such a one as they would expect. And when this client also becomes rude with you, you know there is this temptation to tell such a person something which you don't really mean".

A midwife declared that the exceeding pressure on them is resulting in "staff being highly demotivated". A midwife affirmed that "nurses don't feel supported, nobody cares for them"; and "we get no support on the personal or professional level" declared another midwife. A health manager could see it in plain view that "you see that you are also not being taken care of, you see if you are not being cared for, you are tired, you get the burnout". With some health professionals left bemoaning that "there is no recognition from the government"; "the government likes to use us, but we don't get compensated for this"; and "the government is sometimes impractical". So from the nurses' perspectives "it is difficult to urge nurses to treat others with care, dignity, etc., when their own bosses and colleagues don't do the same to them". Sadly, to one nurse "working to me nowadays.....nursing..... is no longer a call or a passion, now I just do it to earn a living. The motivation or morale died a long time ago. It was there, but no longer. Previously there was something that was driving me to do the caring, but I realised that nobody cares about me. So now I just go like it is any other job".

Demotivation and frustration also arise from the inability to continuously update and improve their knowledge and skills. One midwife reported that "I don't even get a chance to go on rounds with doctors often. How am I supposed to broaden my knowledge on care of patients because we learn through the rounds and we have CMEs (continuing medication education). I will not learn on the rounds, I will not go to CMEs as my colleague is here all alone, I have to work with her". Another midwife stated that "although we have CMEs, because of shortages of staff we are unable to attend them. So yesterday there was a case study on obstructed labour, I really wanted to go but I was unable to ". Yet, a health manager cited that CMEs are an excellent way of "empowering nurses..... let me get all new things about the area that I am working, that would be a great incentive for us."

Giving Birth at Home

Atmosphere

As mentioned earlier women mainly give birth at home "because home is good, because I am surrounded by my people". As a health worker recognized, "of course in the home deliveries the woman feels like she is around people that she is aware of all of whom are looking forward to her happy delivery and everybody is expectant of receiving the newborn. So everyone is happy and ready to celebrate. So she feels happy and more relaxed". A mother from Narok recounted that "I began my labour at home surrounded by the women of my community". Another midwife complemented this by saying "even me given a chance I would like to be around people I know. Here you find in the morning a blue sister, in the afternoon a green sister, and at night a white sister". Whereas in the community, even if attended by a

TBA “she lives in our community, I know her well”, making the women completely comfortable.

The community members are a critical component of home births. Women reported there to be between three and ten women accompanying them during birthing. Women profess to the advantage of this saying “at the birth some of my neighbours were holding me up, rubbing my back, encouraging me, and helping me with water, milk and tea. Having them around me was a great help especially when I was experiencing lots of pain, and feeling very tired, and wanting to give up.” Other mothers added that “by the women holding me I felt like I had strength again, because otherwise, I didn’t feel like I had any energy”; “I was not able to push on my own. They held me as I knelt so that I had the strength to push”; “they all hold me during the pains, giving me the strength to get through them”; and “apart from the practical support they gave me, their actual presence was important and valuable to me and in this way they gave me strength”.

The value of the “mere” presence of community members must indeed hold great value, because in reality some of the women said that they contributed with little else during labour with them recounting that “they were around me just telling their stories beside me while I got on with my work (of labour)”; and similarly “while I was in labour the women are just telling their own stories, singing songs, and keeping me company”. After labour though this is a different case. The mother’s family, neighbours, and community support the woman tremendously and this will be covered in greater detail below in *Postpartum/Postnatal Care*.



Procedures and Practices when Birthing at Home

Most women call a TBA to be present during labour. All TBAs are proud of their services and believe that “women helped by me feel very good about my services” and “my services are well appreciated because I have attended many, many births, I have lost track of how many”. Another TBA declared that “I believe that the doctors, nurses, and midwives in the hospitals see that I am doing a good job and one similar to them as I’m a doctor just like them”. However, some mothers don’t have a TBA in attendance because “the baby came too fast”; “she lives too far”; or simply because they didn’t feel they needed her. Several women felt that “I didn’t have a TBA because I didn’t call her because I have had many children, I don’t need her. The first birth is the one where you are shocked and call her. But by the time you pass the second, third, fourth, fifth time, you’ve passed the test haven’t you?” with another mother confirming that “because I have had so many babies, I will know when a complication is arising. I feel it in my body”.

One of the great advantages cited of birthing at home is that women can “work through early labour. Particularly the first labour is very long and being at home enables you to go around working and not focusing too much on the pain”. As a midwife confirmed, “it is very difficult for a woman to go to hospital and wait around for two to three days just waiting for the baby, they would rather be at home and getting on with their work”.

When birthing at home in some cases there can be no restrictions whatsoever on what the mother is permitted, or not permitted to do. Home birthing mothers declare that “we walk around in and out the home, lie down, get up, drink some water, anything we want”. Furthermore, “because she [the TBA] knows, she was encouraging me to take certain positions and do certain movements with my body to help the baby come out faster”. However, some communities do have some restrictions, e.g., “I wanted to go outside and walk and they wouldn’t let me because they said it was too cold and this would make the baby go back up. However, inside I was allowed to move around as I wished”; and “I was also not allowed to touch my abdomen, I don’t know why”.

Mothers and TBAs alike though emphasised that the greatest difference between birthing in hospitals and at home is the positions enforced during labour which is a major reason for preferring to birth at home. A woman in Narok adamantly held that “home is much better; lying on your back is bad”, whereas another in Isiolo said “we birth on our knees, only women in hospitals lie on their back”. A TBA in fact voiced that “the only difference I saw [in the hospital] is that they make a woman lie down to give birth and here women do it on their knees”.

The other significant fear that women have of birthing in health facilities – including by those who use the health facilities as well – which rarely occurs at home is episiotomies. The mothers who birth at home say “she didn’t cut me”. When discussing these possibilities with TBAs they all seemed quite vehemently against

this practice, with one confirming that “I have never had to cut open the woman; we have a way of positioning the woman to help her if the baby is big” and another citing that “I know how to use my fingers to help a big baby come out to make sure that I have never needed to cut a mother”.

If a woman does tear, at home they do not repair these “they heal by themselves” and sometimes “we treat with salt water”, or “we boil water and wash the tear sometimes with salt or *Omo* and it rejoins and heals all on its own”. It was clear though that for some TBAs the state and health of the perineum is not of great importance as one confirmed “I haven’t seen any woman who has teared very badly, but after the baby is born and the mother has bathed, I don’t approach there [the perineum/vagina] and see again. Our main concern is the baby comes out and the mother bathes”. As two nurses in Isiolo pointed out, “these people do suffer; imagine a woman getting a tear there, it is in a *manyatta*, with all the [risks of] infection”, and “if this mother is to birth again she may have problems due to ragged scar tissue, there are problems there”.

Another grave concern of mothers, touched upon a bit earlier, is vaginal examinations. The vast majority of mothers and TBAs said “no, no, no, we [she] never put our fingers inside a woman”. However, when discussing other issues a few TBAs indicated otherwise, for example that “during the birth, when the head is crowning, I often put my fingers in to guide the baby’s head from going side-to-side”; “we do sometimes insert our fingers into the woman once we are wearing gloves or these [sugar, plastic] bags to ensure that the head is coming out properly”; and “I sometimes break the baby’s bag (amniotic sac) if the baby is coming out and it hasn’t broken as I need to hold the baby’s head”. So it appears that they do not insert their fingers into the vagina for routine assessment, but do so otherwise, for other purposes.

Various practices are reported for encouraging mothers vocally during labour. Many women and some TBAs report to actively encourage a woman to “push” once she is in labour, whereas others say that “whenever I asked her how I was getting along, she didn’t answer me directly, she just told me not to worry, that everything was going fine”. However, some health professionals believe that “at home TBAs just tell them to wait and wait, that their time hasn’t reached yet”.

TBAs also “help with the bag of the baby” (placenta). Most TBAs stated clearly that “we do not pull on the chord”; “I only assist it to come out from the outside, by massaging, I do not put in my fingers”. Instead “when the bag of the baby isn’t coming out properly, we massage her abdomen gently and it comes out”, or “we find out where it attaches in the womb and we know how to massage it there to release it”. A mother claimed however that their TBAs “ensure that the placenta comes out and that it is complete. If there are any remaining pieces, she helps to take them out. She uses her hand to take any pieces out. When she is unable to take it all out she sends the woman to the hospital for further assistance”. In some of the communities visited though, women and TBAs reported that “in our community there are some

women who know what to do especially when the baby's bag refuses to come out". In one community they added that "there is one young lady who knows how to take out even the smallest piece that is left. We don't know what she does, but she really knows that work very well".

Similarly to health facility care, in the home setting the umbilical cord is tied (using string) and cut using a new, razor blade. This is done either by the TBA or by "our colleagues". Some women and TBAs claim to do so "wearing gloves that are given to us by the clinic", however, health professionals and some TBAs admit that "sometimes we attend to the mothers without gloves". In some of these cases "we use the bags of sugar if we don't have gloves, two on each hand" (they purchase new, clear plastic bags used to package sugar in bulk).

Another major incentive of birthing at home as opposed to the hospital is the financial accessibility. Many women and TBAs reported not to receive any financial payment at all for their services. "Our doctors are not paid for their services, not even with other things" (in kind). Whereas some mothers reported that the TBAs "had a cup of tea with us", or "she went home with some sugar, flour, and vegetables". For those who received financial payment, two reported to have paid KSh. 400 and one paid KSh 500.

It was interesting to note that although it is commonly reported that TBAs are more 'gentle' or 'kinder' than their counterparts in the health facilities, this is not always the case with one women reporting that they "tell the women to push and if you are fearful they slap you, until the baby comes out".



Capacities of TBAs

It was reported that most TBAs “when she visits, she massages my belly with oil to see how I am getting along. This massage helps a great deal”. Then she “just sat beside me and did nothing apart from massage me and talk to me and give me verbal encouragement.” While other mothers cited that she “kept encouraging me that the baby’s coming just now” and “despite my doubts, she kept encouraging me”.

Apart from the few activities that TBAs do contribute towards during labour, many women highlighted their actual inactivity. “The doctor [TBA] comes to wait for the baby. While I am in labour she just sits. She just catches the baby when the baby comes out”; “she cuts the cord, helps with the placenta, and nothing more”; and “the doctor [TBA] just helped me to make sure that the baby doesn’t fall to the ground and nothing else” were the claims of three mothers. With a mother adding “the woman at my first birth was the same. There is nothing more she did”.

Some women though were okay with the TBA’s inactivity saying “the doctor [TBA] didn’t help me, I helped myself. She just swept.” Another woman emphasised that “I got no help from anyone. The pain is my own. So what are the other people coming to help me with? You just pray because God will be the only one to help me. So other people only help me with their prayers”.

Having said this, the TBAs don’t consider their lack of ‘intervention’ to be a reflection on their skills. One TBA in Narok remarked that “I have previously accompanied a woman to hospital and I saw their services there were very nice, just like ours here at home”. “When the mother calls us we assess them first. We know, we are also doctors and we know how to assess. If we see that everything is okay and we know she is going to birth smoothly, we can’t send her to hospital, she will just have her baby at home” claimed another TBA. A couple in Isiolo continued that “the baby’s and the woman’s bodies know what to do” and “when God is ready, he will bring the baby out into the world”. However, the TBAs do recognize that health professionals in the health facilities do have a wider scope of skills “as they have read a lot and in fact it is them who come and teach us”.

However, the actual level of skills and training of individual TBAs varied tremendously and this was recognised by the mothers themselves. Generally women accepted that “the older TBAs know their work much better from experience”. Many of them were extremely passionate and diligent about their work with a TBA in Narok proclaiming that “I started this work as I had the courage and wanted to help. I consider each birth a learning opportunity and I learn more and more with each birth. I haven’t received any support or training from any group. There was an NGO offering training to TBAs, but I didn’t attend”. Another TBA in Isiolo though confirmed that “I attended an Action Aid one-week workshop where I learned a lot of new and useful things that have helped me with my work”.

The perceptions of health professionals of the capacities of TBAs also vary widely. A health manager pointed out that “TBAs have the basic know-how to attend and assist with normal birth and are able to assess some of the complications like if there is a lot of bleeding”. A midwife interviewed added that “they are able to detect some of the danger signs”. And yet a health manager stated that “all they do is wait to receive a baby. As much as they say they can assess if the baby is alive or dead this is only possible through foetal monitoring and assessing the foetal heart rate, which they don’t know how to do”.

Complications and Risks when Birthing at Home

The impression given by most of the women and all the TBAs is that complications in labour are the exception rather than the rule as has been indicated several times in this report. Many women felt that “if a complication arises we have our traditional doctors” (TBA). Moreover, all TBAs spoken to reported “there has never been a case of complications arising in the middle of labour [that they had attended]”, and some of them cited that whenever they detected a potential risk “we tell the mother to go immediately to the doctor”. One mother proclaimed though that “women in our community trust our TBAs only because they have never been to a hospital”.

The risks of birthing at home and with TBAs have long been cited. In this study, these impressions remained with mothers and health professionals alike. A mother in Isiolo cited that “the bad thing of birthing at home is if you have low blood or fluids. If these are low and you birth at home without the help of doctors of the hospital you may die”. A woman in Narok shared that “if I get a problem at that time [during birth], there is nothing that she [the TBA] has to help me, which is why hospital is better”. And yet another mother emphasised that the risks at home where why she would rather go to hospital when she said “if the baby doesn’t come out properly you need a doctor to help you. Our doctors here in the community can’t. They just wait for the head of the baby to come out and then they help you. They don’t know if there are any problems inside, for example if the baby is coming out feet first, they don’t know, that is why it is better to go to the hospital where they can help you”. As for the concern of excessive bleeding of haemorrhage, TBAs were generally calm about this danger with one in Isiolo stating that “I haven’t seen a woman who bleeds a lot after having a baby”, and another in Narok claiming that “if the woman is bleeding a lot we ask that a goat is slaughtered and soup made for her to drink. It eventually all comes out and she is well”.

Health professionals generally believe that TBAs “can assist, but with a complication there she would be useless”. “From when the mother goes into labour and goes into the maternity, her progress is monitored and in this way the health provider is able to detect any potential health issues and refer if necessary. Whereas at home the TBAs just wait” were the sentiments of one health manager. Furthermore, “women delivering at home are at risk of developing fistulas because they think it is normal delivery so one may be telling a woman to continue pushing or bearing down, where as in the medical setting there are some cases when this is not advised”.

According to a health manager if a complication arises TBAs “use their own manoeuvres”. This was confirmed by a TBA in Isiolo who casually remarked that “even if the chord is coming out before the baby (cord prolapse) we just massage it back in again” (externally through the abdomen).

Another major risk for both mothers and TBAs (and other community members involved in the care of birthing women) is the transmission of communicable diseases. As one health professional put it “now the danger is mainly about infection transmission, that is where the problem is”. A CHW stressed that “now things are different, and you see the TBAs don’t even put on gloves and the risks for TBAs of contracting communicable diseases and transmitting these to the newborns are high”. “They are [even] unaware of the interventions for PMTCT (prevention of mother-to-child transmission)” cited a health manager. This was reaffirmed by the use of “sugar bags” instead of gloves when the latter were not available as discussed above in the section on *Procedures and Practices when Birthing at Home*.

A health manager in Narok felt strongly about the importance of “once the information reaches the communities and the mothers see the need that as much as they would like to be delivered by the TBAs but they are putting both themselves and their babies’ health in danger, there is no mother who doesn’t want to have a healthy baby. Once the information is there, and she realises that as much as the TBAs are treating them nicely they are also exposing them to certain unforeseen risks” health-seeking behaviour will be modified.

Referrals and Transfers between Home and a Health Facility

Some of the TBAs readily stated that “if I see it [the baby or the placenta] is taking too long we send her to the hospital”. A mother confirmed this by giving her example whereby “initially she [the TBA] tried to help get the rest of it [the placenta] out, but it kept slipping away. She realised she couldn’t. She said I was afraid, as was I, and that she didn’t know how to remove it and that I should go to a doctor immediately”.

However, most TBAs were very proud that “I have never been forced to transfer a woman to hospital”. Another one confirmed that “I don’t know what women do when they encounter complications during labour at home, I have not seen that and a woman having to go again to the hospital”.

Health professionals noted though that this is not necessarily a positive indication. One health manager shared that “they are able to detect some of the danger signs, but they still don’t transfer. They still aren’t ready to send the mother”. This reluctance was hinted at by a TBA who said that “we help each other out and when there is a problem then we go to hospital, however normally there isn’t a problem so there isn’t any need”. This reluctance was confirmed by a mother who shared that

“the women and the TBA will try their best, but if she fails, there are vehicles to take the mothers to hospital”.

A significant point to note is the role that is played by husbands in authorising and ensuring transfers to hospitals. One mother said that “I told the women who were with me that I was feeling pain in my belly and back and they told me to push. I pushed, and pushed, for three days until I had no more energy. Finally, my husband said I should be taken to hospital”. Apart from the authorization often required from husbands, they are also greatly involved in accessing transportation and ensuring the financial means to obtain the health services. One mother in Narok said: “my husband had to go a long way to make a call to arrange for transportation to come and get me and take me to the health centre. He had to go and look for someone to borrow a phone then call someone to come from Uasin Gishu to pick me up. I stayed at home for two days in a bad state waiting”.



Role of TBAs in Maternal Health

TBAs are well esteemed members of their communities – by all the women and men alike. Health professionals are well aware of this affirming that “TBAs are important people in the community” and a health manager stating that “TBAs play an integral part in care giving during pregnancy as well as birth”. Health professionals have gone further to credit them for their minimum skills and abilities as outlined in the section above on *Capacities of TBAs*.

A local midwife felt that “if the women have difficulty getting to the hospital because of distance the TBA can help, but there are still problems associated with that”. “Lack of skills of TBAs is the key issue” declared one health professional. So the general consensus of health managers and midwives was that “we have an issue with TBAs,

although we can't do away with them completely". To better make use of them, one health manager proposed that "before we establish the health facilities systems, we could use them as our lead people, reorienting them towards new roles of facilitating referral".

Postpartum/Postnatal Care

There is a stark contrast in the postpartum/postnatal period between those seeking formal health services and those who are cared for at home.

In the hospital many mothers reported similarly to one mother who shared that "I had to walk on my own to the postnatal ward without any help. The nurses carried the baby. I was feeling very dizzy and I told them and they told me not to worry that it would pass. I came on my own feet. They left me with my baby. I made up the bed myself before I could rest with my baby". Further on, women state that "the doctor passes every day and gets everyone's names and then leaves. They don't talk any further with us"; "from when I came to this ward they haven't assessed me or told me anything"; and "since arriving on this bed, nobody at all has spoken to me (over 24 hours), they haven't come close to me. I haven't spoken to anyone again". Only one mother in Isiolo cited though that "they come and give me medicines and asked me how I have slept. They also examined the baby. They also showed me like this, and this, how to breastfeed my baby".

Apart from interaction, and medical attention, many of the women, particularly the new mothers are hungry for information and guidance on how to care for themselves and their babies. Two mothers in Narok quoted that "I wasn't given any information or advice, after the baby was born nobody has shown me anything"; and "I wasn't given any guidance to breastfeeding, I am just trying, trying". A similar situation was found in Isiolo, although a poster was stuck up in the postnatal ward saying in English that mothers should breastfeed within one hour of giving birth, and the one hour had been corrected by hand to read 20 minutes. A young, first-time mother in Narok shared that "I breastfed my baby only because my baby cried. If I could find someone to help me, show me, it would be good as I have never done this before".

Again, though the issue of human resource constraints severely impacts upon postpartum/postnatal care. As a midwife in Isiolo pointed out "sometimes I am here all alone and I have to tell a mother about breastfeeding, about family planning, talk to her about newborn care, postnatal care, all those things and that is not a lecture that will take less than 30 minutes. I have 10 women here waiting to be discharged, there is another woman screaming in delivery, there is a baby in the newborn unit who needs my care, and there is a patient needing to be taken to theatre, on a sincere note how long will I take with that mother as much as I want?".

With regard to follow-up postpartum/postnatal visits, the uptake of these is extremely low. One midwife observed that "the majority of women don't come for

postnatal care at two weeks as they are requested to, but they do at six weeks as they come for immunization for the baby and for family planning". One of the health managers feels that "one of the reasons we aren't able to capture postnatal women because they come to clinic long beyond the six weeks period is because women [who birth at home] bleed a lot". Interestingly though, in Narok a large proportion of women are "often forced to seek healthcare during the postpartum period only because of the mouth sores" - an extremely common postpartum ailment of no known aetiology reportedly found in that region.

The blood loss concern was confirmed by many mothers who admitted that "for those who birth at home, the postpartum period is often marked by "a lot of blood that remains behind in the abdomen, whereas in the hospital they make sure it all comes out. This makes you feel more lazy at home".

However the immediate postpartum/postnatal period for women who birth at home continues along the same lines as the labour, being a very community and celebratory affair. Very importantly to mothers they state that they are "able to have a hot cup of tea right after giving birth". Another mother shared that "the women of the community, after the baby's born, we make tea and slaughter a lamb for the baby, we eat other celebratory foods, and oils and talk about the arrival of the boy or girl. The birth of a child is a big celebration".

Furthermore, another TBA described that "I help make the bed for her, someone goes to get water, another firewood, another sugar, and even the husband is very active, we help her bath, we wash the clothes, we cook well for her, and we support her greatly. She can't sleep in her bed that night alone. We help sweep and clean the house you can come in soon after the birth and you won't realise that a woman just gave birth there".

Postpartum women at home are cared for greatly by their female family members, neighbours, community members, and sometimes their TBA. One mother claimed that "after the baby was born everyone left and my mother-in-law stayed behind and slept with the baby all night"; and one TBA reported that "I live with the new mother for one to two days. I help her wash, give her traditional herbs, etc. After that I return to my house and continue to visit the mother every day during daytime. I know this is an important time so I can't leave the mother and baby".

A few mothers revealed though that their TBAs didn't give them all that much support during the postpartum period. One mother said that "the following day she came to visit me and check on me, however, she never touched (examined) the child"; and another citing that "the doctor (TBA) doesn't remain with the family afterwards, she takes the placenta and buries it. She doesn't go far though and comes by to visit me every day".

Supporting mothers and babies during the postpartum/postnatal period all the cultures living in these two Counties, observe the rite of "we stay inside the home for

a long time, about one month in the house without going out". Some stay at home for 40 days and some the "baby stays inside the house, mothers can leave though". During this period the mother "finds someone else to do her work for her. Her work for that time is just to breastfeed her child". At the end of this period "we go out for the first time after one month when we take the baby to the clinic" (for vaccinations). Many community members stated though that "you are permitted though to take them out to the clinic and then return right back". Another mother confirmed that "but if the clinic comes they can attend it because clinic is something good".

Male, Family and Community Participation in Maternal Health

Male, family, and community participation is an integral part of improving and ensuring maternal health and is duly emphasised in all national health policies and guidelines. Despite this, apart from the support offered by fathers, and family and community members described previously, according to one health manager in general "maternal and child health has been left to the women; the man's role ends as soon as the woman is pregnant". This was reaffirmed by another midwife who recounted that a few times it even happened whereby "sometimes dads who come to well-baby clinic with a one month old when the nurse asks him what the baby's name is he turns to his wife and asks her what the baby's name is".

During ANC "husbands never show an interest in whether their wife goes to clinic or how it went, they don't even ask" claimed a midwife. One woman cited that "sometimes I went with my husband sometimes I went alone. He only went inside to see the nurse with me once though. I don't know why he didn't come in the other times. Maybe because he sees only women he feels embarrassed". Another mother reaffirmed the sentiments of this previous mother saying that "if he were to participate, the community will make him feel like "ehh this man is sat on".

Yet the health professionals feel that "making them bring their wives to ANC we have to make them feel participants". Enlisting their participation from this early stage has tremendous benefits according to one midwife as "they [the men] hear it [health education] directly from a health practitioner, they will take it more seriously and make an intervention. Because the woman attends the clinic she is given health education and given interventions that she has to follow, but she lacks the support of the husband [to follow them]".

When it comes to labour many women are bound to feel "going through that pain [and] you begin to ask yourself where now is this gentleman who made me pregnant?". From the experience of one midwife the men from certain ethnic groups "want to escort their women all the way to maternity, whereas the others leave them at the main door". One midwife reported that because of this "you find women here all alone and without their partners". Women cite that in some cases "my husband was present and gave the consent for the procedure"; whereas "our men stay with us outside the ward and listen out for when the baby will be born"; or "my husband

went out walking and returned the following day". This is often because "in our culture our men aren't allowed to be close by to a woman who is birthing. They aren't even allowed to eat in the house for about three days". But it is also sometimes because "the doctors asked him to leave, but I wanted him to leave also".

Many health professionals feel specifically that "if we can get more males involved we would have conquered a lot". In seeking to achieve this, the health workers employ strategies such as "here [ANC] we give first priority to mothers who are accompanied by their husbands. I ask the others in the queue for permission for them to move to the front so that others also realise why they are jumping ahead and that there is an advantage to coming with their partners".

As some health professionals have discovered though "there are times here that the national policies of having a birth partner doesn't apply. "I will not allow a birth partner in the labour ward unless there is consent from the birthing woman. Either a male or female partner. She may want her mother in law or her sister with her. But you see it's a very big problem here because if the lady isn't circumcised she won't allow any of her relatives to come in with her and see which leaves her all, all alone. So you see the partner knows the anatomy of his spouse so he is better suited to accompany the mother. So that is not applicable here because of the circumcision issue". According to another midwife "when these circumstances happen at home while the TBA is attending the delivery after the baby is born she will just cut the clitoris. And you can't report them because it is a shame that you were circumcised as an adult".

In addition to this, there are other risks to male, family, and community participation. As one midwife pointed out "community members sometimes do damage though and whenever the mother is accompanied by other women we see a lot more cases of occiput-posterior babies (face up, i.e., not in the optimal birthing position) because either in hospital or already from home she is being encouraged to push with every contraction so the baby isn't allowed to engage in an optimal position. Even though we guide a woman on how to breathe with every contraction, as soon as we leave the room we here her being told to push. If a mother is not advised early she has difficulty in 2nd stage [of labour]. That is the study we have done here".

Community-Based Maternity Health Services

The availability and scope of community-based health services was widely brought up by women and health professionals alike.

Several of the more remote villages visited exclaimed that "our government has forgotten us here" as no health services were available to them anywhere near their homes. Many mothers confirmed that "we would also like to have a hospital nearby here. Of course everyone would go and birth there if it was close by because most

women say the reason they can't go is transport". Similarly one health manager advised that "as they don't want to go to the District Hospital, have maternity-centred facilities, more of them distributed optimally". However, offered another one, "as it will take some time for more accessible facilities to be built, maybe going house to house and visiting the women and telling them the importance of delivering in hospitals and the dangers of staying at home" may be the safer option. On the other hand, a couple of TBAs felt though that "there isn't any assistance women giving birth in our village need that we can't provide for them". They all felt though that "we get no support in our job only from God".

One midwife felt very strongly that "we are trained and called community health nurses, but how often do we go to the community?". Several midwives adamantly stated that "in every community there should be someone that all pregnant women, all postpartum women can go and see"; "if there were enough people on the ground you could refer these women back to them and ensure that there is some continuity of care"; and "if there was someone who would go to these women's homes and talk to them about postpartum care, hygiene, environmental hygiene, newborn care, cover all the gaps that I was unable to fill [in the hospital]. But these people were withdrawn yet I am supposed to do all the clinical work as well as the work of the community nurse which is not practical".

Some of the health professionals recognised that "the only way is to empower the community. When we do this the pressure on us will be less". Health workers in Narok stated that "we must therefore "strengthen the community strategy by increasing CHWs. However, as one in Isiolo pointed out "we have CHWs, but these CHWs in the economy of today they are supported with KSh. 2,000 per month. But you see these people also need to earn a living. They are called voluntary, but even the pastors of today aren't voluntary, let alone health workers. With 2,000 how long are they going to volunteer? 2,000 is very little with the current economy. If we had people who were salaried, they are taught, they are empowered, they come here and work with us then we will be able to see the results that we want to see". Importantly as well, "CHWs are now being trained to be responsible for a set number of households. It shouldn't be only about obtaining and feeding data and statistics".

Mothers from the community though stressed that "[more of] the CHWs need to be women" and health managers also emphasises, that "they need to be equipped with adequate communications to contact the hospital and possibly bicycles to visit all the homes".

Apart from the facilities and the personnel, the communities also require the supplies to adequately provide health services. "We [CHWs and TBAs] have been trained that we must use gloves. Sometimes though we don't have them and we are forced to use new sugar plastic bags instead." Two TBAs reiterated that they "would appreciate supplies of gloves and rubber aprons to help facilitate their work".

All in all though, it still remains that “TBA’s are so influential especially where there’s low literacy. If my 15 year old is in labour the first port of call will be the TBA for direction on what I should do, especially when even that TBA who was present at my birth” professed one health manager. Therefore possibly as a TBA herself suggested, “we would like more trainings because we know more children will continue to be born here”.

Socio-Cultural Issues

Socio-cultural factors are well known to significantly influence the health status of women and the uptake of health services. Although this wasn’t an area that was deliberately questioned about during the interviews, they were readily brought up and discussed demonstrating just how much they permeate and influence maternal health. This is visible throughout this report however, more of these are going to be expanded upon here.

Socio-cultural Constructs

One factor that is pervasive in maternal health throughout the world in different forms, not only in Narok and Isiolo is the socio-cultural constructs of pregnancy and birth. In the cultures living in these areas, “great value is given to pregnancy and childbirth”. “Having your own children is a good thing. Children are your life and the life of your husband. They are the lives of everyone.”

In general, “women always look forward to giving birth. It is something good. It makes them a mother and a mother is greatly valued”. And as the women approach childbirth they are spoken to extensively by other women on what to expect. The messages that women receive differ slightly, but are commonly along the lines of: “women are told that birth is painful, but it’s a good thing as it brings you a new life to spend your life with you”; “women say that birthing is painful, but you shouldn’t worry as it passes. You may feel like you can’t get through it, but you will, and there is an end”; “we don’t fear labour. What can one do, the baby must come out anyway no?”; and “you tell them that if you manage to tolerate the pain then you will have a baby, if you can’t, you won’t”.

These perspectives and those discussed earlier clearly demonstrate their positive views and attitudes of the natural course of pregnancy and labour. This is in fact one of the challenges faced by health professionals who say that “the difficulty is linking that state [pregnancy and childbirth] with illness” and thus the need to “shift perceptions on the risks and dangers”. One mother in Narok though felt that “you know things have changed nowadays, it’s not the way things used to be. Our bodies have changed. In the past women birthed easily and women didn’t lose a lot of blood”. The challenge according to health professionals therefore remains to conduct “education and awareness creation with the women” and “raising awareness, for

example through health education sessions, de-stigmatising health professionals, and enhancing peer and community interaction and support to improve overall health”.

Family Planning

Socio-cultural status, awareness and education also all influence birth spacing and family planning, which also hence impacts upon childbirth outcomes. The vast majority of women interviewed felt strongly that “I will continue to birth until the end”; “we continue to give birth until God stops your babies”; and “I want to have the number of children that God wishes for me”. The spacing of their children in most cases was observed not to be too bad at all, however, as illustrated here, they all had numerous children. Apart from geographical and financial access to family planning services, similar to those encountered for maternity services, socio-cultural barriers also exist. For instance, “our religion refuses family planning, it says it is *haram* (sinful). Some doctors say that family planning has side effects and others say no, so we can’t know. Many use it and you can hide, but God is seeing no?”. Yet other women have to find ways of obtaining family planning support, like one woman in Narok who shared that “when I leave the house after 40 days I will go to the clinic before my husband comes back to the bed, to get medicine for family planning”.

Female-Genital Mutilation/Cutting

In Narok and Isiolo, female genital mutilation (FGM) continues to affect women during childbirth as well as service provision. According to one midwife in Narok “we are yet to see a change in the numbers of FGM”. And in Isiolo a midwife explained that “the majority of Boranas and Somalis even with the third baby they will get an episiotomy even sometimes the fourth. This is because when you suture an episiotomy you suture what you cut, so you leave behind again the very small hole that you met. Sometimes you give bilateral episiotomies and she will still tear however much you support that perineum, even if they are birthing a child of two kilograms”.

In the home setting “if she [TBA] attends a birth of a woman who hasn’t been circumcised they have to “pay” her a cow as she only deals with women and if a woman hasn’t been circumcised it means that she is still a girl and therefore should not be having a baby. That is an incurred cost to her. So the cow is like a fine”. Although as mentioned earlier, a midwife was of the opinion that in addition to the possible fine, the TBA will perform the cut once the baby is born. No TBA though reported to have served any women who had not been circumcised yet. However, some women in the community noted that “now FGM has been disallowed, but we have heard that there is a good difference experienced in childbirth for those not cut”.

Apart from the physiological challenge and risks this act presents to a mother during childbirth and the postpartum period, it also adds a lot more pressure on already strained health service providers. "Conflict sometimes arises when some women raised in different parts of Kenya who may not be circumcised but are accompanied to the hospital by their relatives" recounted a midwife in Isiolo. "It is upon me to manoeuvre the situation". Another midwife was forced to support a woman "who gave birth in the corridor because I had to promise that I wouldn't cut her. Anything I held she thought were scissors so she told me sister lift up your arms. Only to realise that when she was being circumcised when she was eight or nine years it was done by someone who worked in a hospital using a pair of scissors and she is still very traumatised by scissors. My options were either a dead baby or a third degree tear needing to be repaired in theatre. And she got the latter". As trying as these situations are they make the midwives feel "so proud, I felt so encouraged, because at the end of the day we need to help those who want to be helped".



Early Marriage

Some of the women interviewed for this study admitted to be younger than 18 (one who had already had her second child), and most of them admitted to having got married at very young ages, one as young as 10 years old. In one community in Isiolo they claimed that "women usually marry at about 15 years old here".

The general public are increasingly becoming aware of the legal ramifications of early marriage though. Therefore according to one health manager "they are advised prior to coming not to say that they are younger than 18 otherwise the children's officer will be called. This is a very tricky situation for us because we don't want to begin procedures while they are still in the hospital as they go back to their

communities and further discourage people from using health services, but we give the children's officer the details to follow them up in their communities".

Early marriage is another cultural practice in some parts of Kenya that impacts significantly on maternal health and outcomes. As one midwife explained that "young girls have very small pelvises and big babies can't go through and they therefore have to have CSs". Whereas in the community a TBA said that "the younger women are sometimes smaller and I have to give them a cut".

Maternal and Neonatal Mortality

A study on childbirth in Kenya would not be complete without a discussion on maternal and neonatal mortality.

A midwife in Isiolo estimated that "about one mother a month dies. We find it difficult to find the reason why because they turn around half way and we only hear about it. It is [however] usually women from the most remote areas". The health professionals in Narok confirmed that "they come when it is too late". "Of course at home there is a lot of bleeding. Several years ago a woman died just seven kilometres kilometres away from the hospital because by the time they found transportation after taking her to the roadside in a wheelbarrow it was too late" shared a midwife from Isiolo.

The TBAs and women in the community though all stated that they "have never experienced mothers dying" and "I have also never seen a woman who has died near her time for giving birth". A TBA in Isiolo revealed however that "we haven't heard of any women who have died as a result of childbirth in our area, but from the area we came from yes (they were IDPs). There was once a woman many years ago who gave birth to twins well and once she gave birth to the second one we could just see her switching off. This was when this road didn't have many cars. We heard about another woman in Daaba they also had that problem a woman gave birth and went just then and there. But you know Daaba also getting a vehicle is a problem".

In contrast though, TBAs and women in the community admit to high numbers of stillbirths and neonatal (child) deaths. "We have lost several babies and there is nothing we can do" was the response of one woman in Narok. Another mother in Narok stated that most of the children are "children who are born already sick and die soon after birth". The same situation was found in Isiolo where in one area it is reported that "we don't however hear of children dying in the first month of life, just a few here and there that correspond with illness but not that very many nowadays. You see people nowadays understand these things. But you know some children you can see even when they are born they aren't okay". A TBA from another community in Isiolo shared that "there are many children though who die, about one a year. These children are all already dead in the mother's abdomen and are born dead. I haven't seen though any babies dying in the first few months after being born".

CONCLUSION

As with most social issues, the situation of childbirth in Narok and Isiolo is complex and the factors contributing towards this are multifaceted. Despite common opinion, maternal health is about more than just women and health. In Kenya, as in most of the world, the very act of bringing life into the world is determined by power, politics, education (both of the 'clients' as well as the service providers), socio-cultural factors, and all too frequently poverty. Yet what continues to prevail is that childbirth is a highly significant personal, familial and community rite of passage that is deeply emotional and must be viewed and addressed with great reverence.

As childbirth and maternal health cross both the private and public spheres of life the current narrow perspective taken by the health sector only serves to fuel antagonism towards this approach of this unique, normal and natural phase of the lifecycle. Birth is not only a biological event. Anthropological research shows that there are no known societies where birth is treated by the people involved as a merely physiological function. Pregnancy and childbirth are indeed not illnesses that need to be managed, but periods requiring heightened vigilance and care with potential risks, the risks being what need to be managed. Greater respect and sensitivity must therefore be employed in finding the middle ground between barriers affecting uptake of services and skilled care in particular and the provision of adequate and appropriate services for women and their families and communities.

This means that we need to question more the prevailing bio-medical models of provision for maternity care, both from the perspective of current evidence-based knowledge as well as from a commitment to women's empowerment and human rights. This has been encouraged since the 1994 International Conference on Population and Development (ICPD) when the paradigm shift was made towards broad-based promotion of sexual and reproductive health as human rights through strengthening of health services and dealing with the underlying social determinants of health. But greater emphasis continues to be placed on the former and not much on the latter. Research around the world, particularly those studying quality of care, continue to stress the importance of interpersonal rather than technical issues and care, yet this is not being heeded.

All the same, even within the technical realms of care, quality is of the essence. As much as health strategies and practices are purported to be evidence-based it is increasingly reported around the world that maternity care is one of the main areas of medicine where transgressions in this is highest. This was frequently illustrated during this study. In some cases the reasons for this was simply that the national and/or World Health Organisation (WHO) standards and practices were not being followed. However, what is increasingly evident is that practices that are outdated and have been proven to be inappropriate or not ideal are still very much in use. Not only here, but world over we are seeing "an epidemic in [unnecessary] obstetrical interventions.....[and] practices which were once routine in the West and are now

being discredited have been widely exported to developing countries, who frequently lack the means to update their knowledge”¹³.

It is therefore imperative moving forward in addressing women’s health and wellbeing in Kenya that frameworks and strategies are made specific and relevant to our settings and which are steeped in quality, women-centred care. This is very much in line with the goal of the Kenya Health Policy of “attaining the highest possible health standards in a manner responsive to the population needs.... The policy will aim to achieve this goal through supporting provision of equitable, affordable and quality health and related services at the highest attainable standards to all Kenyans. It is designed to take the Country beyond the traditional health services approach towards a focus on health, using a Primary Health Care approach which remains the most efficient and cost-effective way to organize a health system”¹⁴. And obtaining and including women’s voices, as sought here, in these policies and programmes is vital to genuinely serving women’s needs.

Moreover, more effort must be made in protecting and promoting the wellbeing and rights of women and their babies throughout the country and tackling the disparities in health indices witnessed at the sub-national level which aren’t necessarily reflected in national figures. The outcry on maternal and newborn/child mortality is obviously not loud enough and/or the energies behind the outcries are not being sufficiently translated into action. Certainly, they are not going far enough. Indeed the unwarranted deaths are a scandal and an abuse of human rights, but so is the trauma, both subtle and deep, be it physical, mental, or emotional, that women and children have to endure be it from being forced to birth at home or obtaining inadequate quality services in a facility where they go to seek *care*.

Taking a human rights approach to women’s health clearly reveals that “women’s reproductive health risks are not mere misfortunes and unavoidable natural disadvantages of pregnancy but, rather, injustices that societies are able and obligated to remedy”¹⁵. As argued further by midwife Sister Anne Thompson in authoritative Panos Institute report *Birth Rights: New Approaches to Safe Motherhood*, “if hundreds of thousands of men were suffering and dying every year, alone and in fear and agony, or if millions upon millions of men were being injured and disabled and humiliated, [some] sustaining massive and untreated injuries and wounds to their genitalia, leaving them in constant pain, infertile and incontinent, and in dread of having sex, then we would all have heard about this issue long ago, and something would have been done”¹⁶.

Absolutely women’s health and rights are a power and political issue, from their home all the way to the national and even global levels. Women’s continued low status in society results in neglect of their wishes and wellbeing, poor quality services, and lack of attention to their human rights. In recent years, as demonstrated by grossly inadequate improvements, the strong political will, particularly among senior politicians, has faded since the peak observed in the aftermath of the ICPD. Even within the health system we see that the prioritization of maternal health is

waning. Increasingly, efforts are diluted due to the trend towards addressing the triple burden of disease (communicable, non-communicable, and injury/violence). Yet the value and opportunity of *prevention* through healthy pregnancies, births, and early childhoods is being totally underestimated and missed. It has also become blatantly obvious that focusing on management and technical issues will not get us very far and what is needed is to unleash the power necessary for change.

Childbirth and maternal health in Kenya not only presents tremendous challenges for ensuring the health and rights of the majority of the population, but it also provides us with a ready and unique ‘point of entry’ where from we can collectively work towards transforming our futures and our society entirely. The new Constitution of 2010 and the broader government development framework, Vision 2030 capture this well in recognising that the rights and health of all Kenyan citizens are central pillars in ensuring “Kenya becomes a globally competitive and prosperous nation with a high quality of life”^{17,18}. It is imperative therefore that the whole nation becomes aware and stands behind our individual, collective, and national obligations and visions of the future in recognition that they are inextricably dependent on how we care for pregnant and birthing mothers.



RECOMMENDATIONS

The voices of the mothers and their care providers in Narok and Isiolo provided great and important insight, food for thought, and numerous indications and concrete proposals on how their needs can be better met.

Similarly to the reporting on their perspectives, the recommendations have been clustered according to the most prevailing issues at hand. They are provided below in no particular order of value or importance.

Human Rights Mainstreaming

As enshrined in the Constitution of Kenya and committed to under numerous international, regional and national laws, treaties, and conventions, the human rights of *all* citizens, particularly the most vulnerable, must be protected and promoted. This includes the right to the highest attainable standard of health by *all* citizens. Hence potential solutions to achieve human rights mainstreaming in maternal health are:

- Strengthen advocacy and action within the health sector to prioritise resource provision towards universal coverage of critical services as well as towards more equitable health services. These must be based on both the increased burden of health risk and ill-health experienced by women, as well as the greater neglect of women and communities in the most rural and remote parts of Kenya.
- Further reinforce the protection and promotion of human rights in health institutions by:
 - Developing comprehensive citizen's/patient's charters and going beyond displaying them in written [English] form around hospitals. Citizen's/patient's charters are more than just what the hospital's vision is and what the charges are for the different services. They should encompass the rights and obligations of both parties – the service providers and the service users. Furthermore, the service providers must find means and modes of effectively communicating these to the clients and ensuring their comprehensive understanding of them. This includes health service providers embodying and facilitating that the obligations and rights are respected and honoured.
 - Increase awareness and understanding of the scope of human rights and gender based violence in relation to maternal health. This includes how some policies and practices actually condone and perpetrate human rights violations and gender based violence. This should be conducted throughout the health system and include personnel such as policy and programme developers, managers at the various levels, doctors, midwives, CHWs, TBAs, hygiene staff in the health facilities, etc., etc.

- Move towards instituting mechanisms by which transgressions of human rights can be confidentially and transparently investigated and addressed by women and their families as well as by health professionals.
- Raise awareness of human rights in relation to maternal health within communities.

Political and Multi-Sectoral Support for Maternal Health

Galvanizing political and multi-sectoral support for maternal health is closely linked to mainstreaming human rights. As mentioned earlier, in order to halt our stagnation in this area and make tangible positive changes, everyone, particularly the most 'powerful' in society need to be fully behind this agenda. It isn't enough for senior politicians, members of parliament, and other ministries to shrug their shoulders and think and say 'maternal health is a health issue and thus the problem of the MOPHS and MOMS'. To tackle this atrocious situation, women, their families, and communities definitely need well-functioning health facilities, health professionals, and ambulances, etc., but assure positive and improved health outcomes they also equally need safe and nutritious food, water, education, accessible roads, communication systems, means of livelihoods, etc., etc. Therefore, maternal health and rights needs to be raised in the agenda of all individual national sectors as well as on the national level as a whole, alongside strong leadership and political will from the very top in order to drive this agenda forward.

Innovative Approaches to Maternal Health

As discussed a bit earlier, we in Kenya must dare to challenge and analyse the current model of approaching maternal health. A creative and effective model, or models, needs to be established, which at the core are empowering and organised around women's legitimate needs and expectations. The bulk of possible approaches are based around improving community/primary health care approaches, as mentioned earlier, these are not only the most cost-effective, but also the most effective in assuring optimal health outcomes. Some possible approaches are:

- Establish autonomous or semi-autonomous maternity or birthing centres, as are becoming increasingly popular around the world, where wellness, care, and vigilance are the essence as opposed to illness and disease. These can be promoted and used for the vast majority of normal/low-risk pregnancies and births. As these types of units are less resource-intensive the scope of opportunity of establishing higher numbers of these, which will be closer to the communities, is increasingly higher.
- Re-integrate TBAs into the health system. In honestly and transparently assessing our current reality, discouraging (banning) the use of TBAs has made little, or possibly even no, impact on health outcomes in Kenya, as seen by our maternal health indicators. We are therefore tremendously under

utilising a great resource that is available to women and to the health system. In the meantime we are also losing a great wealth of our indigenous knowledge and know-how in the process. There is no doubt that their roles need to be re-oriented and their capacities enhanced, however, energies need to be diverted from fighting against them to harnessing their immense power of influence and passion towards maternal health.

- Strengthen CHW programmes to contribute further to maternal health. In the spirit of devolution of powers enshrined in the new Constitution as well as the primary health care approach desired by the health sector, the foundation of the health system, which is at the community level (CHWs), must be established more formally within the health system and be significantly empowered. This is nowhere more evident than in maternal health. As a midwife pointed out, “if CHWs were educated, equipped, empowered, and supported”, tremendous headway would be made in improving nutritional status; uptake of ANC, maternity, PNC, and family planning services; awareness of danger signs and complications during these periods; vital health promoting practices, e.g., breastfeeding, hygiene, etc., and much, much more.
- Incorporate birth preparedness and complication readiness into all focused ANC as well as community health programmes. Current evidence indicates that increased awareness on how to stay healthy during pregnancy and in the postpartum/postnatal period, the need to have a skilled birth attendant at birth, recognizing danger signs for complications, and establishing a plan on what to do if they arise, would significantly increase the capacities of women and their newborns to remain healthy, to take appropriate steps to ensure a safe birth and to seek timely skilled care in emergencies¹⁹. Health workers should therefore assist women and their families in assessing and planning their options for the necessary support they may need. This may be such as setting aside money for the birth, transport arrangements, securing of care for other children, etc.
- As a care provider proposed, set up and strengthen mobile and outreach services, if feasible for maternity services, but at the bare minimum for ANC and PNC. This approach is essential and has shown to be very effective for the more remote areas of Kenya.
- Explore possibilities of ‘maternity waiting homes’ to serve women from some of the very inaccessible areas, particularly for high-risk women to ensure that they are in close proximity to skilled care and the health facilities and services that they may require. One midwife in Isiolo recounted that there was such a *manyatta* within the hospital compound in Garissa where women would come at 38 weeks gestation and in terms of maternal health outcomes, this programme had a significantly positive impact.
- Establish and nurture greater public participation in decision making and local social accountability for all maternity health facilities. This would further guarantee that health services are really meeting the needs of local women

and their communities and promote mutual responsibility for the protection and promotion of women's health and rights.

Evidence-Based and Women-Centred Care Strategies and Practices

As discussed, the care given to women must be appropriate, not harmful, empowering, and of the highest quality, grounded in evidence irrespective of where the woman seeks it. Hence some strategies which may be adopted to better achieve this are:

- In assessing and revising maternal health (reproductive health) policies, guidelines, and practices ensure that they are in-line with the latest evidence of practice. The adoption of some of these latest evidence-based practices, for example movement and positioning during labour and childbirth, social support during labour, just to name a couple, are likely to require huge transformations for the health care providers as well as in the health facilities. However, this will make certain that women receive optimal quality care and that the best possible health outcomes are achieved.
- Develop mechanisms in the education systems of health professional to ensure that the curriculums used are up-to-date with the latest evidence-based knowledge and practices. This not only means in terms of the clinical care, but also the non-clinical care. As a health manager illustrated "when they come to the maternity they should not only find midwives, but ready midwives, ready to rub their backs. When I was a student midwife I used to rub their backs, I know it is very soothing with this and with the guidance on breathing. You know she finds the labour shorter if she has someone there to support her".
- Develop mechanisms not only to train on-the-job health professionals on the latest evidence-based knowledge, but to assess and ensure that they are putting these all into practice.
- The above recommendation is closely tied into the tremendous human resources for health problems and needs. The Government and partners should continue putting great emphasis on the key human resources for health issues, particularly for maternal health. This includes the training, recruitment, equitable deployment, retention, motivation, and support of health personnel working in maternal health. In addressing these, it is critical that the perspectives of the health professionals themselves are taken into consideration and are incorporated. Moreover, other actors and civil society should also boost advocacy in this regard and support the Government in whichever capacity towards this end.
- Diminish and de-stigmatize the clinical nature of maternity spaces in health facilities by making them more friendly, empowering and community-oriented. This would include things such as: allowing the woman self-determination and control over her birthing experience in the absence of emergencies (even during which there is often room for some influence); making the spaces feel more 'homely' and concealing away all non-essential

medical equipment; allowing women to be accompanied by a birth partner of their choice at all times; and improving visiting policies, just to name a few.

Male, Family, and Community Participation in Maternal Health

It was widely recognised in this study as it is worldwide not only that male partners and family and community members have the capacities to significantly contribute towards maternal health but also the abilities to do so. Their involvement is therefore key. Some potential solutions to enhancing their participation include:

- Step-up the current strategies and approaches to ensuring women attend ANC, birthing, and PNC services with their husbands or partners. Furthermore, ensure that all health care providers are well aware of these policies, strategies, and protocols so that this is encouraged at all times in normal care and as far as possible during emergency care.
- Further develop incentive programmes for men (their women and families too) who attend services together. For example as one midwife proposed, “holding monthly gatherings to enhance partnership with the community” and giving them rewards such as mosquito nets” to help them “feel proud and important and that is the time we teach them the importance of taking care of their wives”.
- As discussed above in birth preparedness and complication readiness, involve the fathers, families, and communities in establishing birth preparedness and complication readiness protocols and programmes to support the women in their communities, e.g., through collective maternal health savings programmes, transportation schemes, etc.
- A health manager proposed bringing on board “chiefs and sub-chiefs” to be more greatly involved in some capacity in pursuing and promoting maternal health in their communities.
- As mentioned before, further raise awareness on women’s health and rights within communities and provide support for community mobilization efforts towards addressing these.

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