

**DETERMINANTS OF THE CHOICE OF PLACE OF DELIVERY AMONG  
EXPECTANT MOTHERS IN KITUI WEST SUB-COUNTY, KITUI COUNTY,  
KENYA**

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## DECLARATION

This Thesis is my original work and has not been presented for examination in any other university or institution.

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## **DEDICATION**

This work is dedicated to my husband Dominic whose support and encouragement throughout has been unwavering. I would also like to express my deep appreciation to the Syuma's family for the support and encouragement and especially, Henry Syuma my brother in-law, Josphine Kioli my Sister in-law, Nzamba Kioli my nephew and Christine Syuma my Sister in-law of South Africa

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## ABSTRACT

This study explored ‘Determinants of the Choice of Place of Delivery among Expectant Mothers in Kitui West Sub-county’. Specifically, the study assessed pregnant women’s choice of place of delivery and reasons for their choice, determined where the pregnant women finally delivered and what influenced their choices. The third aspect was to find out opinions about pregnant women’s choice of place of delivery from caretakers who accompany pregnant women from pregnancy to childbirth. The caretakers included; nurses and traditional birth attendants (TBAs). The study was guided by Health Belief Model (Becker and Maiman, 1977), Autonomy Theory of Empowerment (Anderson, 2013) and the Predisposing Factors on Health Care Utilization Model (Andersen, 1995). The study population comprised expectant women in their third trimester. One hundred and thirty five ANC-attendees were drawn from 10 randomly sampled health facilities in Kitui West Sub-county for the survey. Further, two Focus Group Discussions (FGDs) of 12 and 10 pregnant women were carried out within the 10 sampled health facilities. Besides, key informant interviews were held with eight TBAs and five nurses. This research was both qualitative and quantitative. Data was collected from the women regarding their perspectives on choice of place of delivery during pregnancy and after delivery to determine what informed their actual place of delivery. Quantitative data was captured into SPSS and descriptive and inferential statistics were used in analyzing data while qualitative data was captured into Nvivo, themes derived on the basis of study objectives, parental and child nodes derived as per the direction of responses. Presentation has been done on the basis of graphs and frequency tables including pie charts for quantitative data while verbatim quotes were used to amplify qualitative data. The findings indicate that out of 135 ANC-attendees, 93 percent had intended to deliver in a health facility, 2.2 percent had planned to deliver at home, and only about 1.5 percent were waiting for their husbands to decide their place of delivery. The remaining 3 percent were waiting on other relatives to decide on where they were to deliver. In regard to the 30 non-ANC-attendees, 60 percent of them had planned to deliver at home, 23 percent intended to deliver in a health facility, while 14 percent were undecided. The remaining 3 percent were waiting for their fathers to decide where to deliver. In relation to where these two groups of women actually delivered, 64 percent of 135 ANC-attendees delivered in a health facility while 36 percent delivered at home. Of the 30 non-ANC-attendees who were considered as a control group in this study, 90 percent delivered at home and 10 percent delivered in health facilities. Overall the key reasons of where the women delivered included awareness of complications that could occur during childbirth, complications during childbirth, confidence in the TBA, quick labour, previous complications during childbirth and influence of significant others on where the baby should be delivered. Previous safe deliveries emerged as the main reason for choosing to deliver at home for 30 non-ANC-attendees. Targeted sensitization on the value of health-facility-based deliveries should be rolled out to actors and/or chain of decision makers in an expectant woman’s life. Among these in Kitui West are; women at child bearing age, significant others who would include husbands, mothers-in-law, mothers of pregnant women and TBAs. This study recommends MoH to train TBAs in basic skills in order to give standardized maternal health care services. It also recommends a further research to explore why education attained did not influence place of delivery.

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## **ABBREVIATIONS AND ACRONYMS**

**ANC:** Antenatal Care

**CHVs:** Community Health Volunteers

**DPHN:** District Public Health Nurse

**GOK:** Government of Kenya

**HBM:** Health Belief Model

**HIV:** Human Immunodeficiency Virus

**IMRs:** Infant Mortality Rates

**KNBS:** Kenya National Bureau of Statics

**MMRs:** Maternal Mortality Rates

**MOH:** Ministry of Health

**OBA:** Out Reach Based Approach

**SDGs:** Sustainable Development Goals

**SSA:** Sub-Saharan Africa

**TBAs:** Traditional Birth Attendants

**UN:** United Nations

**UNFPA:** United Nations Fund for Population Activities

**UNICEF:** United Nations International Child Education Fund

**WHO:** World Health Organization

## DEFINITION OF TERMS

***Breech presentation:*** Most babies will move into delivery position a few weeks prior to birth, with the head moving closer to the birth canal. When this fails to happen, the baby's buttocks and/or feet will present which complicates normal process of delivery.

***Transverse Lie:*** Is a sideways position. The baby has his head to one of his mother's sides and the bottom across her abdomen at her other side. This is normal before 26 weeks. By 29-30 weeks, it is expected that, the baby's head to be down, or at least breech. Therefore if the baby's position in the uterus is transverse at the time of delivery, the woman undergoes caesarean section since the baby cannot be delivered normally.

***Placenta praevia:*** A condition in which the placenta partially or wholly blocks the neck of the uterus, so interfering with normal delivery of a baby.

***Neonatal death:*** This is death that occurs during the first 28 days of life while *Infant mortality rate* is the number of *deaths* per 1,000 live births of children under one year. The *rate* for a given region is the number of children dying under one year of age, divided by the number of live births during the year, multiplied by 1,000.

***Perinatal deaths:*** This refers to the number of fetal deaths or an early neonatal death. It is measured by the number of perinatal deaths per 1000 total births while a *Stillbirth* refers to an infant that has died in the womb having survived through at least the first 28 weeks of pregnancy.

***Prolapse of the umbilical cord:*** Is a complication that occurs prior to or during delivery of the baby. In a prolapse, the umbilical cord drops (prolapses) through the open cervix into the birth canal ahead of the baby. The cord can then become trapped against the baby's body during delivery and interferes with the process of delivery.

***Antepartum haemorrhage:*** This is bleeding from or in to the genital tract, occurring from 24 weeks of pregnancy and prior to the birth of the baby. The most causes of Antepartum haemorrhage is placental abruption.

***Significant others:*** In regard to the pregnant woman in the context of this study, significant others included; husbands, mothers-in-law, parents of the unmarried pregnant woman and grandmothers.

## **1.0 CHAPTER ONE: INTRODUCTION**

### **1.1 Background of Study**

In Kenya, 98 percent of pregnant women countrywide attend ANC and only 61 percent give birth in a health facility; the remaining 39 percent give birth at home assisted by a relative or traditional birth attendant (TBAs) (KNBS & ICF Macro, 2015). Although the percentage (61 percent) of pregnant women who give birth in a health facility seems encouraging because it is above average, nonetheless the number of pregnant women who give birth at home in different counties in Kenya raises a concern. A case in point is that there are counties with less than 35 percent of women who deliver in a health facility. Some of these include; Wajir 18 percent, Samburu 25 percent, West Pokot 26 percent, Marsabit 26 percent, Tana River 32 percent, and finally Kitui, which is the study area has 46 percent (KNBS & ICF Macro, 2015). As discussed later in this paper, 488 maternal deaths per 100,000 live births occur in Kenya (KNBS & ICF Macro, 2015). Most of these deaths are associated with pregnancy-related complications, especially home deliveries where TBAs cannot deal with emergencies such as difficult labour, bleeding during labour and after delivery (Turshen, 2000). Yet most of the pregnant women, according to data of various counties, still deliver at home, and without assistance from trained professional health providers.

The Government of Kenya (GoK) underscores the importance of pregnant women delivering babies in a health facility because of obvious advantages. These include availability of facilities and trained personnel in case of any childbirth related complications. There are also extended medical care services for pregnant women who may have conditions such as diabetes, hypertension and human immunodeficiency virus (HIV) that require specialized medical care during delivery (Mungai, 2015).

The foregoing efforts are in cognizance of the realization that it is during delivery when mother and infant are likely to face high risk of dying because of problems associated with childbirth. Giving birth in a hospital minimizes infections that are likely to affect mother and baby. Besides, giving birth in a hospital has many advantages because it creates an opportunity for mothers to engage with the health workers to be informed about best breast-feeding practices, nutrition, hygiene, and family planning issues. As pointed out by Jones (2013), pregnant women feel safest giving birth in a hospital. This is because emergency personnel and equipment are available if the woman develops complications or needs medical attention. In a hospital, there is timely emergency response to any complications related to mother and baby during childbirth. It is the best option available in the event of a caesarean section. Further, immediate pediatric attention is available should the newborn need medical attention. It is also the safest environment for the mother at risk because it has round-the-clock observation for mother and infant (Jones, 2013). There are varied maternal complications globally. They include; high blood pressure, anaemia, prolapsed uterus and pelvic inflammatory conditions, severe bleeding which may happen after birth and infections after birth which may be caused by unclean environment (Magadi, 2000b). There is also a likelihood of HIV transmission from mother to child, more prevalent in home deliveries. The rate of the HIV has increased from 15 percent to 45 percent depending on different regions (Milmo, 2013). Diamond (2000) documents that; worldwide statistics show that 30-100 pregnant women die from these childbirth related problems.

Interestingly, 75 percent of all maternal deaths associated with childbirth are preventable or treatable if the woman seeks timely medical help (United Nations Children's Education Fund-UNICEF, 2015). To ensure safe deliveries, pregnant women should attend the antenatal care (ANC). This would give the medical staff an opportunity to check if there were any potential complications to the mother and the baby during pregnancy and at the

time of delivery. It ensures that appropriate measures are taken early enough to prevent death of mother and baby during pregnancy and childbirth. Good care of the woman during pregnancy and childbirth significantly reduces maternal and infant mortality rates (World Health Organization-WHO and UNICEF, 2003). Turshen, (2000) laments that, if pregnant women fail to adhere to ANC guidelines, it may adversely affect the fetus. For instance, in the year 2010, 58,000 newborn babies died worldwide from neonatal tetanus. That implied that the mothers did not receive tetanus toxoid during pregnancy. Alternatively, contaminated instruments were probably used to separate the umbilical cord from the placenta (Turshen, 2000). Another condition that may also affect an infant is sexually transmitted diseases (STDs). Without proper and early management of STDs in pregnancy, the baby could be born premature (Meme, 2002). Pregnant women must thus have increased awareness about the importance of giving birth in a health facility (Kumbani et al., 2013).

Many women worldwide die from common obstetrical problems that could be managed by simple technologies that could prevent and treat pregnancy and labour complications (Meme, 2002). Every minute around the world, 110 women experience pregnancy and labour related complications, with 11 of them dying (Kibaru et al., 2006). The views of Meme (2002) and Kibaru et al., (2006) regarding childbirth complications, concur with those of Magadi (2000a) who postulates that many of the deaths during childbirth are associated with home deliveries assisted by TBAs. According to the United Nations-UN (2009) Report based on Sustainable Development Goals (SDGs), half a million pregnant women die globally every year because of problems during birth or during the first 6 weeks after delivery. Ninety nine percent of these deaths occur in developing countries. Half of these 99 percent cases of pregnant women's death are in Sub-Saharan Africa (SSA), with a third in Southeast Asia. Moreover, 85 percent of these deaths occur in low resource settings which could have been prevented (WHO et al., 2015).



In the United Kingdom (UK), only 20 percent of women may die during delivery, most of them living in the marginalized areas of the country. The low mortality rate in these regions is explained by the high percentage of access to ANC and maternity care services. For example, in Eastern and Central Europe about 95 percent of pregnant women and postnatal mothers utilize maternal health care services including safe deliveries in health facilities (Milmo, 2013). Some countries have introduced preconception care initiatives programs in order to enhance antenatal care services. These include; high-income countries such as Italy, the Netherlands and United States of America (USA) as well as low and middle income countries, for instance, Bangladesh, Philippines and Sri Lanka. Such programs ensure that women enter pregnancy in good health and consequently give birth in a health facility (Leo, 1992).

In India, records of deliveries from health facilities indicated that majority of births occurred at home without assistance of a professional health care provider. This explains why half a million women continue to die from maternal causes each year in India (Milmo, 2013). In this part of the world, TBAs who apply traditional methods of assisting in delivery, view excessive bleeding after birth, a medical emergency, as a good sign of cleansing the womb (Kibaru et al., 2006). Maternal mortality rate (MMR) in Afghanistan in 2013 was between 460 and 1,000 per 100,000 live births. Majority of births occurred at home; only 34 percent deliveries were attended to by trained medical personnel (Rahmani & Brekke, 2013).

Lawn (2006) intimates that between 2000 and 2004 more than 60 million women in SSA delivered their babies at home without the assistance of a professional health care provider. This phenomenon can be paralleled with the US perinatal mortality rates of pregnant women. The women who gave birth at home were 3 times more than hospital deliveries. Surprisingly, infant deaths for these women were 10 times more than those of the women who delivered in a health facility (Crespign & Savulescu, 2014).

In the African region, infant mortality rate (IMR) is 81 per 1000 live births, approximately 7 times more than in the European region which is 11 per 1000 live births. In most cases, these deaths relate to maternal complications during pregnancy or at birth (Global Health Observatory Report, 2015). In SSA region, there are few countries with less than 100 maternal deaths per 100,000 live births. In these countries the average rate is 597 maternal deaths per 100,000 live births. In Uganda, Senegal, Nigeria, Mozambique, Eritrea and Angola, death rates are 1,000 per 100,000 live births (Kenya National Bureau of Statistics - KNBS & ICF Macro, 2015). For every woman who dies in this region, 20 others have to endure long-term illness. Besides, 1 out of 5 children dies before their fifth birthday (Rahmani & Brekke, 2013).

In Nigeria, some estimated 75,000 women died during pregnancy at the time of giving birth around 1990s. Ethiopia is among countries with the highest number of maternal and infant deaths and morbidity rates. The MMR in 2000 was 816 per 100,000 live births, and the IMR was 113 per 1,000. In the 1990s less than 10 percent of pregnant women received professionally assisted delivery care in Ethiopia (Turshen, 2000).

The lifetime risk of dying in pregnancy and at the time of giving birth is 500 times higher for an African woman than for women in industrialized countries (Mekonnen, 2002). A study by Noka (2008) shows that utilization of ANC and access of maternity services is very low in some African countries, posing adverse pregnancy outcomes. For instance, in Uganda, majority of women, especially in the remote areas prefer to be assisted by TBAs during delivery. Expectant mothers only seek professional health care services when they experience problems during their delivery; this is often quite late. Unfortunately, they do not attain the expected ANC visits hence, occasionally; pregnancy complications are not diagnosed in good time, thus jeopardizing safe delivery (Tuguminize, 2009). On the other hand, IMR was also high. For instance, about 8.8 million infants' deaths occurred globally in

2008. Twenty nine percent of these deaths occurred in Africa and 54 percent in South East Asia (Kumbani et al., 2013). Infants who died before their first year of life globally in 2015 were 4.5 million (Global Health Observatory Report, 2015). Every year 4 million babies died in the first 4 weeks of their life (neonatal period) and 99 percent were stillbirths (Magadi, 2000a).

To make pregnancy and childbirth safe events for women therefore, WHO, UNICEF and the World Bank initiated the global safe motherhood initiative in 1987 in Nairobi. The main objective of this conference was to bring to the world's attention the problem of high maternal and infant mortality rates as mentioned in the preceding discussion. In this connection therefore, the conference aimed at developing strategies to support pregnant women to access ANC and give birth in a health facility. This was expected to reduce mother and child mortality rates. Another element established in this conference was that mother and child mortality rates were higher for women who gave birth at home than it was for mothers who gave birth in a health facility.

After initiation of the global motherhood initiative in 1987, it was expected that the average MMRs would reduce globally by 50 percent by the year 2000. To attain the above goal, WHO, UNICEF and World Bank supported ministries of health and other health implementing agencies to boost access to mother and child health care services internationally. This was to be achieved by providing higher quality maternal health care and family planning services, both in the community and in all respective health care facilities (Kibaru et al., 2006). The fifth SDG, considered by the international community as fundamental to the survival of mother and child, stresses that improving maternal health is key to child survival. Therefore, these international community members were committed to supporting different countries to reduce maternal mortality by 3 quarters by 2015 (Global Health Observatory Report, 2015).

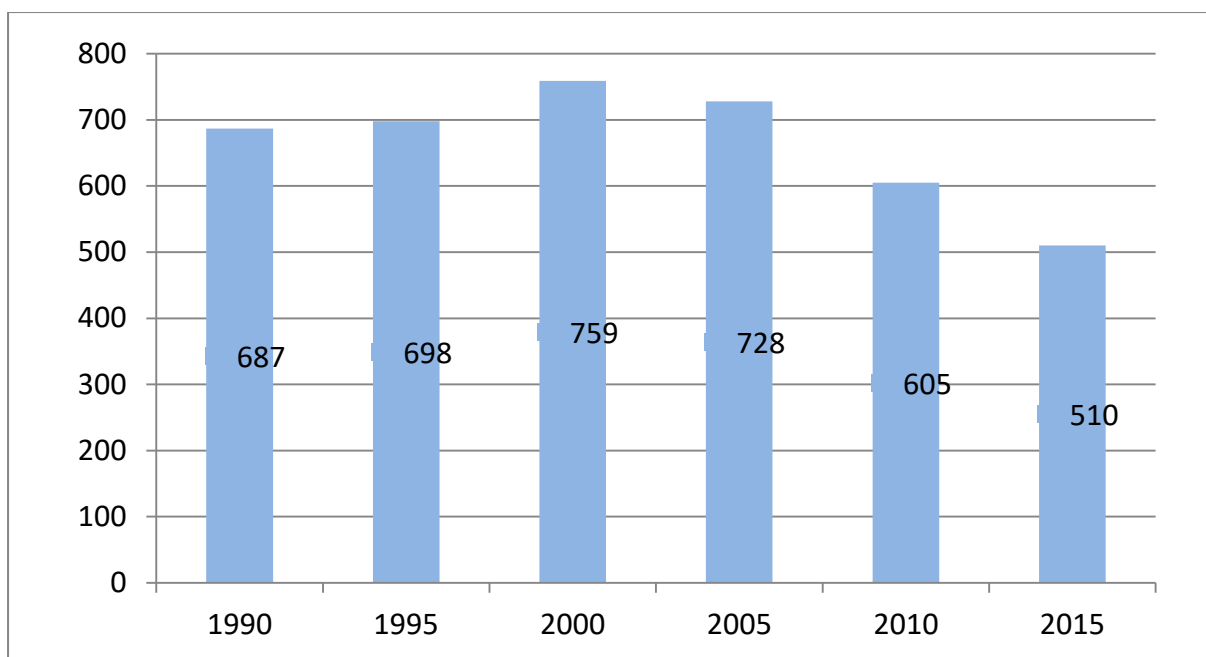
From the foregoing, the vision of the 1987 conference and the fifth SDG was taking a very slow pace indeed to materialize. However, it is notable that the initiatives have faced various challenges. The challenges include; inadequate skilled health personnel, lack of involvement of communities and families in mother and child health care aspects, lack of attentiveness by mothers regarding the advantages emanating from maternal health care services and preference of women to give birth assisted by TBAs (KNBS & ICF Macro, 2015).

Having discussed the situation of maternal health care and its challenges globally and regionally, the study focused on the Kenyan situation as the country of study. From the time of independence in 1963, major milestones have been achieved in health care (Kibaru et al., 2006). Kenya aims at providing an efficient and high quality health care system with the best standards (ibid). In 2003, Kenya anticipated to raise health facility deliveries that were at 42 percent by 90 percent by 2015. Nevertheless, the rise has been minimal. By 2009 deliveries in health facilities had increased by merely 2 percent to stand at 44 percent (KNBS & ICF Macro, 2015). By 2013, 43 percent of births took place in health facilities indicating a drop of one percent in deliveries in health facilities (Owino & Legault, 2013).

Kenya is one of the countries that suffered 65 percent of maternal deaths in 2008 (WHO et al., 2010). These deaths accounted for 7,900 (2.2 percent) of the global maternal deaths (ibid). According to 2014 medical records, 488 maternal deaths per 100,000 live births occurred in Kenya (KNBS & ICF Macro, 2015). These deaths were associated with prolonged and difficult labour, unsafe abortion, ante-partum and post-partum hemorrhage. Most of these deaths occurred at home as the deliveries were being conducted by TBAs who may have not been able to deal with the complications mentioned above (ibid). The MMR was more pronounced in 6 counties: Tana River, Wajir, Marsabit, Turkana, West Pokot, and Samburu where more than two thirds of deliveries were assisted by TBAs (KNBS & ICF

Macro, 2015). These deaths occurred because of improper management of complications during pregnancy and at the point of delivery, prolonged labour, and lack of watchfulness at the first critical hours after birth (ibid).

Pregnant women who prefer to give birth at home find themselves in crisis especially in the event of any childbirth complications. The crisis is compounded when a TBA cannot handle the situation (Angatia, 2006). Such complications could be managed if a woman chose to give birth in a health facility (World Bank, 2015). KNBS & ICF Macro, (2015) put IMR as 29 deaths per 1000 live births in Kenya. The IMR in Kenya was 39 deaths per 1,000 live births (KNBS & ICF Macro, 2015). In 2017, IMR was 37 per 1,000 live births (WHO, 2017), indicating a decrease in IMR of 5 percent after 3 years (2014-2017). MMRs have fluctuated between 687 in 1990 to a high figure of 759 in 2000 and dropping to 510 in 2015. Figure 1.1 on page 9 illustrates the trends of MMRs between 1990 and 2015 per 100,000 live births in Kenya. These deaths are related to pregnancy and delivery complications.



**Figure 1.1:** Maternal Mortality 1990-2015 in Kenya

**Source:** WHO, UNICEF, UNFPA, World Bank Group, and United Nations Population Division: Maternal Mortality Estimation Inter-Agency Group (2015).

Kenya's Vision 2030 focuses on high quality life to all citizens including mother and child. These goals are in tandem with the 2 among the 8 internationally agreed goals for social economic development. These include reduction in child mortality and enhancement of mother and child health. To improve maternal and child health care services, Kenya aims at providing an efficient and quality health care system with the best standards. To achieve this goal, the GoK emphasizes lowering IMRs and MMRs. Further, the GoK aims at providing health care services to those excluded from these services due to financial reasons. Besides, through the support by WHO, UNICEF and the World Bank, the government has put concerted efforts to achieve safe motherhood which is expected to reduce the IMR and MMR (Mungai, 2015).

To complement the GoK's efforts, the First lady Her Excellency Mrs. Margaret Kenyatta, through her 'Beyond Zero Campaign' which was launched on 30<sup>th</sup> January 2014, mobilized donors and private sector organizations and the Ministry of Health, to purchase mobile vans to provide free and comprehensive HIV, including mother and child health care

mobile services in the country (Mungai, 2015). This was with a view to reducing IMRs and MMRs as well as accelerating the implementation of the national plan towards elimination of new HIV infections among infants. The other aim of this program was to increase the number of medical professionals as well as equipping the existing facilities with relevant supplies. Besides, this initiative had obvious benefits towards mother and child (Mungai, 2015). For example, under this initiative, there were ambulances in every county hospital. The ambulances were fully equipped to respond to any maternal emergency cases especially, during transfer of pregnant women from one health facility to another (ibid). According to Diamond (2000), such efforts were meant to facilitate management of conditions that complicated pregnancy and delivery.

The set objective of the GoK has been to reduce MMRs and IMRs. To enhance this objective, the GoK deployed more skilled health-care workers. In addition, it sought to upgrade and equip existing health facilities with relevant equipment and supplies (Mungai, 2015). The GoK also initiated a program to scale down malaria-related infant deaths. Malaria not only accounts for 6 percent of infants' deaths nationally but it also causes maternal anaemia that is fatal to the mother after delivery because of insufficient blood supply in the body. For that reason, the GoK distributes free treated mosquito bed nets to pregnant women to address the issue of malaria (Ochola et al., 2004).

## **1.2 Problem Statement**

The GoK has ensured that all government health facilities offer free comprehensive health care services, including maternal health care (KNBS & ICF Macro, 2015). Moreover, the GoK has scaled down barriers pregnant women used to face in accessing health facilities. Besides, the 'Beyond Zero Campaign' program initiated by Her Excellency Mrs. Margaret Kenyatta, the First lady has obvious benefits towards maternal health care (Mungai, 2015). In an interview with the District Public Health Nurse (DPHN), in charge of the health facilities

in Kitui West Sub-county, she pointed out that, the medical staff were motivated accordingly in order to be effective and efficient. For instance, there was the global fund (Result based funding) whereby Ksh 900 was awarded to the health facility for every child delivered there. Sixty percent of this cash was paid to medical staff as incentive while the remaining 40 percent was reserved for the improvement of the health facility. The government on its part contributed Ksh 2500 for every health facility delivery. This amount went towards development of the health facility.

Despite the efforts put in place to assist pregnant women, they seem not to have taken full advantage of mother and child care services. This is illustrated by the fact that 39 percent of pregnant women in Kenya deliver their children at home as mentioned in earlier discussion in this study. The state of affairs in some of the counties is even worse including Kitui where 54 percent of the antenatal women deliver at home (KNBS & ICF Macro, 2015). What explains this discrepancy, where efforts are made to enable mother and child health care services accessible and yet a big percentage of pregnant women deliver at home? ANC-attendance stands at 98 percent countrywide (KNBS & ICF Macro, 2015). This high percentage is expected to be commensurate with the number of pregnant women delivering in health facilities, yet this does not seem to be the case. The intriguing questions the researcher asked were; were pregnant women aware of the benefits accruing from giving birth in a health facility assisted by a medical health care provider? What then influenced pregnant women to choose where to give birth? This study was therefore two pronged: to explore what influenced pregnant women to choose the place of delivery for their babies and where they finally delivered in Kitui West Sub-county. In this study, expectant mothers and pregnant women are used inter-changeably to refer to women who were pregnant in their 3<sup>rd</sup> trimester at the time the study was initiated.



### **1.3 Objectives of the Study**

#### **1.3.1 General Objective**

To explore influences of choice of place of delivery for pregnant women in Kitui West Sub-county, in Kitui County

#### **1.3.2 Specific Research Objectives**

1. To find out from pregnant women their choices of place of delivery in Kitui West Sub-county and reasons for their choice
2. To determine where the pregnant women finally delivered their babies and what influenced their choice
3. To gather opinions regarding pregnant women's choice of place of delivery from caretakers who accompany these women from pregnancy to childbirth. The caretakers included; nurses and traditional birth attendants (TBAs).

### **1.4 Research Questions**

1. Where did pregnant women initially plan to deliver their babies in Kitui West Sub-county and why?
2. Where did most pregnant women finally deliver their babies and what influenced their choices in Kitui West Sub -county?
3. What views do informants who included TBAs and nurses have regarding pregnant women's choice of place of delivery in Kitui West Sub-county?

### **1.5 Justification of the Study**

This study is appropriate for Kitui County because 54 percent of pregnant women delivered at home assisted by TBAs (KNBS & ICF Macro, 2015). As indicated by KNBS & ICF Macro, (2015), TBAs may not be able to deal with the complications related to

childbirth. This is based on the fact that TBAs predominantly employ traditional methods of assisting in delivery; they may not recognize emergency cases for referral on time (Kibaru et al., 2006). In some cases, expectant mothers and TBAs only seek professional health care services when they experience problems during their delivery; this is often too late to save the mother and the baby. Kitui County had the elements that the study hoped to explore. These included; ease of use of maternal health care services where women attended ANC and had the chance to give birth in these health facilities although some delivered at home. For that reason, this research locale was relevant to the research questions and objectives.

The researcher was prompted to explore the perspectives of pregnant women concerning their choice of place of delivering their babies to understand what really determines their choices. Besides, health professionals design health care delivery services to be consumed by women. It was therefore justifiable for pregnant women to be given an opportunity to share what determines their choice of place of delivering their babies with a view of becoming active partakers of their own health.

### **1.6 Significance of the Study**

This study adds to the data base on this topic. It contributes to the field of knowledge in this area Maternal Child Health Care (MCH) and provides a case to suggest further study anchored on research findings. The study contributes useful information to the existing policy regarding maternal health care services.

### **1.7 Scope and Limitations of the Study**

Some of the non-ANC-Attendees were not readily available for interviews because of their busy schedules. The second Phase of this research required the researcher to interview nurses. However, at the time when this interview was to be conducted, the nurses were on

strike. Fortunately the nurse in charge of the health facilities in Kitui West Sub-county was interviewed in her office since she was not supposed to take part in the nurses' strike as required by management. This research focused on health facilities that provided comprehensive ANC and child health services. The scope of the study extended to interview pregnant women within gestation period between 7 and 9 months who attended these health facilities for ANC as well as those who lived in the environs of the health facilities who were non-ANC-Attendees. The other category of respondents was nurses from the sampled health facilities and TBAs within the environs of the sampled health facilities in Kitui West Sub-county. The health facilities which offered integrated maternal health care services in Kitui West Sub-county were: Matinyani, Muthale (Catholic mission hospital), Kauwi, Kwamutonga, Kauma, Kalimani, Maseki, Katutu, Kiseveni, Iiani (Catholic mission dispensary), Tulia, Zinia, Ndiuni, Kwamulungu, Matinga, Kivani, Syathani, Syokithumbi. Mama Vero, Upendo Clinic, Musengo Clinic and MEMS Clinic were privately owned and did not offer integrated services. A random sampling of the 18 facilities yielded 10 health facilities that offered integrated health care services.

### **1.7.1 Delimitations of the Study**

To respond to the challenge of time constrain of non-ANC-Attendees, the researcher adjusted her timetable to meet them at their most convenient time. To mitigate the non availability of nurses during interviews since they were on strike, the researcher met the respondents from the chosen health facilities in their most suitable places outside their duty stations.

## 1.8 Operational Definitions of Variables

**Dependent Variable:** Place of delivery of the babies: This refers to the option pregnant women made regarding place of delivery that is either in a health facility or at home.

**Age:** Literature emphasizes that age of the expectant woman is known to influence choice of place of delivery. For instance, Kimbi et al., (2014), carried out a research in Tigray region; Ethiopia where they found out that maternal age significantly influenced where a pregnant woman would deliver her baby.

**Level of education:** This entailed determining respondents who had; no education, primary, secondary and tertiary level and establishing whether these levels influenced choice of place of delivery. Owino and Legault (2013) found out that poor usage of delivery health care services could be linked to low educational attainment of the pregnant woman.

Backing the assertion of Owino and Legault, KNBS & ICF Macro (2015) affirmed that the level of education of a pregnant woman could be associated with the likelihood of seeking skilled help in a health facility.

**Religion:** In the context of this study, religion was considered as an influence on choice of place of delivery because different faiths have different perspectives regarding pregnancy and childbirth. Mekonnen and Mekonnen (2002) argue that religion also affects use of antenatal care. In their study they found out that those who followed Orthodox, Muslims and Protestant religions made use of antenatal care than those who followed traditional beliefs.

**Marital status:** It is likely to influence a pregnant woman's place of delivery, depending on whether a woman is married or unmarried. Ebuehi et al (2006) and Mekonnen & Mekonnen (2002, 2003) stated that marital status is related to utilization of maternal health services because married women were more likely to use antenatal care than their unmarried counterparts.

**Previous history of deliveries:** Number of children a pregnant woman had delivered was likely to influence her choice of place of delivery. Worku et al., (2013) maintain that women who had births for the first time were more likely to use skilled birth attendants than women who had delivered several children without childbirth problems. Therefore the previous history of deliveries helped to determine if this was a determinant in choosing place of delivery.

**Occupation:** The nature of work a pregnant woman engages in, may influence her choice of place of delivery. Rahmani and Brekke (2013) carried out a research in Afghanistan established that occupation of a pregnant woman significantly influenced her choice of place of delivery. Falle et al., (2009) who explored the impact of ‘Nutrition Intervention Project’ in Kathmandu in Nepal, posited that there was a relationship between occupation and access of professional health care services.

**Cultural beliefs and practice regarding childbirth:** These cultural beliefs refer to views advanced by communities regarding childbirth. Kibaru et al., (2006) found out that Luhyas believed that the placenta was a sacred organ and so it was imperative for a woman to give birth at home where certain rituals are performed. In this connection, a study carried out by Nuraini and Parker (2011) in Xien Khouang Province, Indonesia indicated that culture was significantly linked with utilization of ANC services.

**Role played by significant others regarding place of delivery:** (husbands, in laws, parents): The role played by significant others in this study meant support or none support towards a pregnant woman by significant others. The support or none support given by significant others to a pregnant woman is likely to influence her choices of place of delivery (Agus and Hiriuchi, 2012).

**Pregnant woman’s determination to use maternal health care services:** This meant if the respondent perceived delivering in a health facility as important. Ebaale (2011) suggests that utilization of health services by antenatal mothers will significantly contribute towards

achieving Survival Development Goal 3 which is about good health and wellbeing. This goal aimed at reducing child mortality by two-thirds and reducing maternal mortality ratio by three-quarter by the year 2015.

**Perspectives of pregnant women towards professional health care providers:**

Perspectives of pregnant women in this study meant the nature of reception a pregnant woman received from professional health care providers. According to Kumbani et al., (2013), one of the reasons why pregnant women did not deliver their babies in a health facility in Southern region of Malawi in the Chiradzulu district was the unfriendly attitude of nurses towards pregnant women.

**Awareness of complications during childbirth:** For the purpose of this study, pregnant women's level of knowledge of awareness was 2 pronged. First and foremost, was the awareness of complications that could occur to a woman during childbirth. The other level of knowledge of awareness was complications associated with a baby during and after childbirth. These two aspects were likely to influence pregnant women's choice of place of delivery. In a study carried out in Southern Tanzania by Mpembeni et al.,(2007) they found out that there was a significant association between awareness of knowledge of maternal and baby complications with usage of mother and child health care services (Mpembeni et al., 2007).

**Awareness of advantages of delivering in a health facility:** Analysis done by Kitui and Davey (2008/2009), in Kenya where 3,977 women were interviewed revealed that; pregnant women who were aware of the advantages of giving birth in a health facility were likely to overcome all barriers in order to reap benefits of the services by choosing to deliver in a health facility.

**Access to health facility:** It was critical to find out from the respondents whether these conditions influenced their choice of place of delivery. In a study carried out by Roro and Hassen (2014) in Ethiopia, Butajira district, it was established that long distances to health facilities may prevent pregnant women from accessing health care services.

**Level of income:** This was about whether the level of income of a pregnant woman influenced her choice of place of delivery. Poor women in remote areas are the least likely to receive adequate health care. Only 46 percent of women in low-income countries benefit from skilled care during childbirth (WHO, 2013).

**Pregnant woman’s past experiences:** This refers to previous history of childbirth which means safe delivery (ies) or problematic delivery (ies). The nature of childbirth experiences is likely to influence a pregnant woman’s choice of place of delivery. Worku et al., (2013), report that women who had births for the first time were more likely to use skilled birth attendant than their counterparts with several children and without childbirth problems.

**Sex of the baby:** One of the informants (a nurse), postulated that if the sex of a baby was known in advance, this knowledge would influence the choice where it would be delivered. The summary and exact measures of these variables were provided in table 1.1 on page 18.

**Table 1.1. Summary of Operational Definitions of Study Variables.**

Variable	Age categories	Measurement
Place of delivery of babies		No. of babies delivered in a Health facility 1
		No. of babies delivered at home 0
Age	16-20-years	No. of respondents who delivered in a health facility in each category 1
	21-25-years	
	26-34-years	No. of respondents who delivered at home in each category 0
	35 & above years	
Level of education	<b>Categories</b>	
	Primary	No of respondents in each category who delivered in a health facility 1
	Secondary	No. of respondents in each category who delivered at home 0
	Tertiary	
No schooling		
Religion	<b>Categories</b>	
	Catholic	No. of respondents who delivered in a health facility in each faith category 1
	AIC	
	Pentecostal churches	No. of respondents who delivered at home in each faith group 0

Table (cont....)

Marital status	<b>Categories</b>		
	Married		No. of married respondents who delivered in a health facility 1
	Unmarried		No. of married respondents who delivered at home 0
			No. of unmarried respondents who delivered in a health facility 1
			No. of unmarried respondents who delivered at home 0
Previous history of deliveries:	Number of children delivered influences choice of place of delivery		No. of children delivered in a health facility against number of children delivered by the respondent 1
			No. of children delivered at home against number of children delivered by the respondent 0
Occupation	Small businesses		No. of respondents who indicated that their occupation influenced their choice of place of delivery 1
	Teachers		No. of respondents who indicated that their occupations did not influence their choice of place of delivery 0
	Subsistence farming		
	Housewives		
	No occupation		
Cultural beliefs and practice related to childbirth			No. of respondents who indicated that culture influenced their choice of place of delivery 1
			No. of respondents who indicated that culture did not influence their choice of place of delivery 0
Role played by significant others regarding place of delivery			No. of respondents who sought permission before choice of place of delivery 1
			No. of respondents who did not seek permission 0
Pregnant woman's determination to use health care services			No. who chose to deliver in a health facility 1
			No. not yet decided where to deliver 0
Perspectives of pregnant women towards professional health care providers			No. decided to deliver in a health facility because of positive attitude by nurse 1
			No. decided not to deliver in a health facility because of negative attitude by nurse 0
Level of knowledge of awareness regarding complications during childbirth for pregnant woman & baby			No. aware of complications of a woman during childbirth 1
			No. not aware of complications of a woman during childbirth 0
			No. aware of complications of a baby during childbirth 1
			No. not aware of complications of a baby during childbirth 0
Awareness of advantages of delivering in a health facility			No. aware of advantages of delivering in a health facility 1
			No. not aware of advantages of delivering in a health facility 0
Access to health facility			No. indicated that distance to health facility influenced their choice of place of delivery. 1
			No. indicated that distance to the health facility did not influence their choice of place of delivery 0
Level of income			No. indicated that level of income influenced choice of place of delivery 1
			No. indicated that level of income did not influence choice of place of delivery 0
Pregnant woman's past experiences			No. planned to deliver in a health facility because of prior problems 1
			No. planned to deliver at home because of previous safe deliveries 0
Sex of the baby	<b>Categories</b>		
	Male		No. who said would deliver in a health facility on account of knowledge of sex of baby 1
	Female		No. who said sex of baby did not influence choice of place of delivery 0

## 1.9 Summary

This chapter has discussed; the background of study which focused on complications related to childbirth, advantages of giving birth in a health facility, maternal mortality and neonatal deaths. It also looked at efforts of different agencies to make childbirth safe. Other areas examined included; problem statement that was drawn from the background of study



and the literature reviewed. The chapter further highlights the guiding research objectives, questions, justification and significance of the study as well as limits, scope of the study and delimits. Discussed also was operational definitions of variables. Flowing from the above discussion, the next chapter focuses on related literature review.

## **2.0 CHAPTER TWO: LITERATURE REVIEW**

### **2.1 Introduction**

This chapter focuses on the theoretical review of literature while highlighting the major theories that guided the study. It also examines various empirical studies related to this research while establishing the gaps this study intends to fill. The conceptual framework of the study is also discussed including the operational framework

### **2.2 Theoretical Framework and Other Theoretical Perspectives**

This study was informed by 3 theoretical frameworks; Health Belief Model (HBM) which was modified by Becker and Maiman (1977), Predisposing Factors on Health Care Utilization Model by Andersen (1995) and Theory of Autonomy by Anderson (2013). These 3 theories were found to be significant and appropriate to this study because of the contribution they made concerning what would influence an individual to utilize health care services.

The HBM is one of the theories extensively used in conceptual frameworks to explain health behavior. The authors argue that for an individual to take health related action, a certain perception about the situation must be conceived. In this study, this meant the preference of place of where to deliver babies by pregnant women was likely to be influenced by a certain awareness that was visualized about place of delivery. The theory was derived from cognitive theory of behavior developed by Bandura (1977).

#### **2.2.1 Cognitive Theory**

As pointed out by Bandura (2001), cognitive theory is rooted in past experience and schemas which are patterns of thought hypothesized to organize human experience and guide information processing about people and relationships. The schemas direct attention, organize encoding and influence retrieval of information. This theory further points out that,

individuals cognitively make meaning of events based on memories, beliefs and expectations before final action is taken. Banda, (2013) points out that, people evaluate events in terms of likely outcomes, weigh how useful those outcomes are and select the courses of action accordingly and a belief that a behavior if well performed will result according to the expected outcome. Therefore the interplay between cognitive theory of behavior and HBM, which envisions that a certain perception about a situation must be conceived, were better placed in this study to predict choices where pregnant women were likely to deliver their babies.

The HBM helps to explain why individual patients may accept or reject preventative health services or adopt health seeking behaviors. It helps to predict the likelihood of a person taking recommended preventative health action and to understand a person's motivation and decision-making about seeking health services (Banda, 2013). HBM is about making choices regarding health behavior. Consequently, the researcher was guided by this theory to explain what influences pregnant women in their choice of where to deliver their babies as this study was an attempt to explain Determinants of the Choice of Place to Delivery by Expectant Mothers in Kitui County, Kenya: A Case of Kitui West Sub c-ounty.

The following constructs of HBM help to make us understand better how individuals make their choices related to health behaviors. The HBM proposes that people will respond best to messages about health promotion or disease prevention when the following 4 conditions for change exist:

*Perceived Severity:* This refers to an individual's view on how serious a health condition is and its subsequent consequences. Although an individual can suspect that the health condition can be apparent, this may not necessarily be an inspirational factor to seek for medical help until one recognizes that this condition may cause serious physical,

psychological and social impact. In this study, this should be understood to imply that perceived complications of childbirth may not be enough to motivate a pregnant woman to seek medical help during her delivery unless she recognizes that these serious conditions can affect her and may have serious repercussions during childbirth.

*Perceived Susceptibility (vulnerability):* Refers to one's assessment of the chances of suffering from a particular health problem. Knowledge of the health problem is a key factor for the individual to understand the circumstances of being at risk which is expected to increase individual's perception of their own vulnerability to the condition. However it is until the individual acknowledges that they are at risk that they seek medical help.

In the context of this study, susceptibility included categories of pregnant women who were likely to experience childbirth complications depending on their previous experience or special medical category. Knowledge on how their risky situation could progress to danger was important. The choices the pregnant women made depended on perception about the situation.

*Perceived Benefits vis-a-vis Barriers:* Perceived benefits refer to individuals perception of the rewards accruing from a particular health behavior. For instance if an individual believes that by performing a certain activity will reduce risk of contracting a serious disease, such a person is likely to conform irrespective of the cost or other related barriers. In this study, perceived benefits and barriers would relate to the case of a pregnant woman who will be guided by the values she recognizes linked to the place of delivery and overcome all barriers connected to the place of delivering her baby. HBM is about patients evaluating events in terms of likely outcomes informed by their perceptions which in turn influence the decisions they make.

### **2.2.2 Predisposing Factors on Health Care Utilization**

Andersen (1995) postulates that an individual's desire to utilize a service stems from the need to do so. If it is a health service, the person should be suffering from a certain condition. The degree of severity and duration the person has suffered will also determine the urge to use the service. Other factors that may contribute according to Andersen include; financial capability of the person, support given by others, the knowledge the person has about the advantages of using the service, the dangers the condition suffered may harbor, how hospitable the service providers are and how determined is the person suffering to overcome all barriers to utilize the service. Finally, access to a service is possible if the recipients have a certain degree of freedom to use the services out of their own free will.

### **2.2.3 Autonomy Theory**

According to Anderson (2013) autonomy is a theory of empowerment. The author points out that to make an informed decision an individual should be self directing, acting on motives and being informed by reasons and values which are one's own. Anderson (2013) further contends that autonomy is not influenced by outside forces relative to a particular situation, but an individual's capacity for self determination. Albritton (1985) adding voice to this discussion on theory of autonomy, points out that an individual directs her own action if only she is motivated to act. For the motivation to be efficacious it should be in harmony with her mental state that represents her point of view on the action. Albritton (1985) further maintains that an individual's point of view is directed by her highest desires which propel her to act. The desire to act is further evaluated in terms of accruing benefits before a final decision is made. Albritton (1985) concludes by contending that if actions are performed implicitly or explicitly then an individual's action is said to occur with their permission.

The views of Anderson (2013) and Albritton (1985) were considered for this study because for pregnant women to choose where to deliver their babies, they were expected to exercise some form of self direction or to be autonomous in making this decision. That is why one of the variables in this study examined whether pregnant women needed to ask permission from significant others before they chose place of delivery. Therefore, the concept of Autonomy and HBM complement one another in that, to make a choice; there must be a motivation and a certain degree of freedom. In this regard, for a pregnant woman to make a decision, she requires a certain level of autonomy and inspiration to do so. The above theories therefore helped to explain what influences pregnant women to choose their place of delivery.

### **2.3 Empirical Review**

Empirical review was done to enhance the study regarding variables which were grouped into 3 categories namely; predisposing factors, intervening variables and dependent variable. Under predisposing factors, descriptive characteristics of respondents were considered. These were; age, level of education, religion, marital status, number of children a woman had delivered, place of birth & reason for the choice, number of children who had died, place of birth and cause of death and occupation of the pregnant woman. Other predisposing factors included; culture, role played by significant others, pregnant woman's determination in use of health care services, perspectives of pregnant women towards professional health care providers and place of delivery as the depended variable.

#### **2.3.1 Reasons for Choosing Place of Delivery**

**Distance to health facilities** could be a barrier for antenatal women to choose to deliver in health facility as observed by Meme (2002). Magadi (2000a) posits that at times road networks may make ease of access of a health facility impossible. According to Roro and Hassen (2014), long distances to health facilities could hinder pregnant women from

accessing maternal health care services. This was revealed by a study carried out by these authors who interviewed women in Ethiopia, Butajira district to find out why majority of them did not prefer to deliver in a health facility. Information was gathered from 81 women through Focus Group Discussions (FGDs). Supporting the same view regarding distance to the health facility, Bruce and Blanchard (2015) confirmed that when health facilities were far away, pregnant women tended to give birth at home. Bruce and Blanchard (2015) study was investigating preferences for infant delivery site among pregnant women in Northern Karnataka, India where majority of women delivered at home assisted by TBAs. On the same subject matter, according to Kitui et al., (2008/2009), ease of access of a health facility increased health facility delivery. Additionally, when Gabrysch and Campbell (2009) searched articles from Pub-Med, Ovid databases, they discovered that majority of pregnant women could not access maternal health services from health facilities which were far away.

The condition of the roads was another aspect that would limit utilization of maternal health care services among the pregnant women as observed by Kitui et al., (2008/2009). These findings were obtained from 3,977 women through a questionnaire where they indicated that poor road networks were hindering them from accessing maternity services which eventually made them to give birth at home. Kitui et al., (2008/2009) further point out that abrupt delivery reduces chances of giving birth in a health facility. Magadi (2000a) further points out that, another hindering factor to accessing delivery services could be associated with low economic status whereby health delivery services are too expensive such that pregnant women could not afford. This is evident in that only 31 percent of pregnant women in the lowest income bracket in North America get some of the recommended health care services while 93 percent of pregnant women in the same region, who are above poverty level line seek all recommended health care delivery services (Grunebaum, 2013).

Magadi (2000a) and Grunebaum (2013) argue that while mothers have full responsibility of caring for the children they may have little or no control of choices regarding economic resources. In reference to this research, the implication of the above argument is that pregnant women may have limited choices regarding place of delivering their babies where finances are to be taken into consideration. Meme (2002) further concedes that pregnant women who work in factories and offices which are incompatible with maternal needs may pose a challenge to them. Another contributing factor to none access to delivery health care services can be linked to some **women who have little or no control** over their reproductive health (Kitonga, 2011). In such cases women usually rely on their husbands or partners or in-laws to seek permission to access maternal health care services. For instance, many Indian women are of the opinion that they have little or no control over their pregnancies and outcomes of the same and therefore believe they have to consult their spouses. This kind of control sometimes causes delay in seeking medical help which may be fatal at times (ibid).

**Distaste and personal views** can influence a pregnant woman's preference of place of delivering her baby. For instance, some of the major reasons related to none access to delivery services in a health facility in North America, Australia and Europe can be said to be connected to; dislike of labour ward tedious procedures, past negative experiences, limited control of self, affordability and unfamiliar environment (Grunebaum, 2013).

**Age** is another determinant that can influence a pregnant woman to utilize ANC and delivery health care services. This assertion is supported by the fact that women between the ages of 35 and 49 are less likely to seek delivery services especially if they have delivered other children without a problem as compared to women who are younger (ibid). Further, Gabrysch and Campbell (2009) established that the higher the maternal age, the less likely for the pregnant woman to deliver in a health facility. The two researchers searched articles from



Pub-Med, Ovid databases and other relevant sources and found out that aged pregnant women tended to delivery their babies at home. Still exploring factors that influenced choice of place of delivery for pregnant women, Gabrysch and Campbell (2009) found out that level of education a pregnant woman attained significantly influenced her choice of place of delivery. The researchers' observation was that increased access to maternal health care services corroborated with higher level of education of pregnant women. On the same note, Kitui et al., (2008/2009) interviewed 3,977 women through a questionnaire to establish aspects which motivated them to choose where to give birth. Their research revealed that women with low level of education tended to deliver at home while pregnant women with higher level of education preferred to deliver in a health.

Poor usage of delivery health care services can closely be linked to low educational attainment of the pregnant woman which is related to poor decision making in health seeking behaviors. Higher level of education is associated with greater use of ANC and delivery health care services (Owino & Legault, 2013). Decision to support antenatal women to give birth in a health facility will largely depend on the level of education and attitude of most significant others (ibid).

**The level of education and economic status** of a pregnant woman can be associated with the likelihood of seeking skilled help in a health facility. Only about 25 percent of antenatal women with low education seek skilled assistance from a health facility as compared to 85 percent of births to women with secondary or higher education (KNBS & ICF Macro, 2015). Apart from low education, some **religious** leaders forbid their followers to seek medical help but instead to pray and ask God to intervene in their sickness for healing (Ndung'u, 2009).

Sometimes accessing delivery health care services will depend on the knowledge, attitude and exposure of the pregnant woman and most significant others especially the husband and the parents if the woman is unmarried (Owino & Legault, 2013). In the same connection, Owino and Legault (2013) further maintain that **lack of awareness of the advantages** of these maternal health care services may create a barrier for pregnant women to access delivery health care services. Kibaru et al., (2006) outline one of these advantages as prevention of transmission of HIV from mother to baby during childbirth or breastfeeding period. This is achieved by the professional health care provider by taking every precaution to ensure that there is no risk of transmission.

To establish whether number of previous births influenced choice of place of delivery, Anyait and Mukanga (2012) carried out a research in Busia district of Uganda to establish indicators that influence women to give birth in a health facility. Five hundred women who had delivered in the past 2 years were interviewed. The results indicated that one of the indicators that influenced women to give birth in a health facility was few children a woman had delivered. According to these researchers, pregnant women with less than 4 children preferred to deliver in a health facility. Gabrysch and Campbell (2009), after searching articles from Pub-Med and Ovid databases and Kitui et al., (2008;2009) after analyzing views of 3,977 women respondents, arrived at a similar conclusion that, the number of children a women had delivered, strongly predetermined where to give birth.

According to Bruce and Blanchard (2015), **social cultural** factors influenced pregnant women in their choice of place of delivery. To explore this hypothesis, the two researchers carried out a research in Northern Karnataka, India where majority of women delivered at home assisted by TBAs.

They interviewed 110 antenatal women who said in part that they preferred to give birth at home assisted by a TBA because it was comforting to be with the TBA because of the care she exemplified. Besides, there was respect from the society for being a mother.

### **2.3.2 Determinants of Place of Delivery**

Cruz and Adams (1976) contributing to the importance of awareness of advantages of delivering in a health facility posit that, pregnant women should be aware of complications that may arise during childbirth. This is crucial so that in case of any eventualities appropriate measures can be taken to save the life of mother and infant. Owino and Legault (2013) contributing to what other aspects may deter pregnant women from accessing ANC and delivery health care services posit that, a woman may lack inner drive to utilize health care services if the pregnancy was unplanned. According to Cotter et al., (2006) in other occasions, **fast progression of labour** can be another factor which may result to a pregnant woman not being able to seek delivery services in a health facility because of time factor.

The role played by **significant others** greatly influenced where pregnant women gave birth as viewed by Anyait and Mukanga (2012). Based on a research carried out in Busia district of Uganda by these researchers, it was revealed that women, who depended on others for decision on where to deliver, experienced difficulties in choosing the place to deliver their baby. This was so because their decisions were constantly influenced by others since they lacked independence in choosing where to give birth. Nevertheless, according to Roro and Hassen (2014) women in Ethiopia, Butajira district, chose to give birth at home assisted by TBAs because members of the family were allowed to be with her during labour and delivery which was consoling.

This aspect of allowing relatives to be with the woman in labour contrasts with the procedures in health facilities where relatives are not allowed in labour wards, observed the researchers. The presence of relatives during childbirth at home made pregnant women to prefer to deliver at home.

Readiness of a pregnant woman to give birth in a health facility was an important factor that could influence her place of delivery. Anyait and Mukanga (2012) maintain that, for a pregnant woman to utilize health care services, she must have strong motivation to do so otherwise, as viewed by Kitui et al., (2008/2009), if this motivation is lacking, health facility deliveries will be considered unnecessary.

Among the intervening variables, the following aspects were considered; Knowledge of awareness of complications that may occur to a pregnant woman and the baby during childbirth, awareness of advantages of delivering in a health facility, access to health facility, level of income, pregnant woman's past experiences and sex of the baby. The level of knowledge of awareness regarding a woman's and a baby's complications during childbirth, and awareness of advantages of delivering in a health facility were tested by Rahmani and Brekke (2013) in Afghanistan. These researchers found out that pregnant women lacked information concerning the importance of utilizing maternity services and the need to deliver their babies in a health facility.

Level of income of a pregnant woman according to Rahmani and Brekke (2013), Roro and Hassen (2014), Bruce and Blanchard (2015) could significantly determine where she would give birth. The results of a study carried out by Rahmani and Brekke (2013) among the Afghanistan women, showed that these women encountered pecuniary difficulties in paying for maternal health care services. A study by Gabrysch and Campbell (2009) revealed that household wealth was an important predictor to where a pregnant woman would give birth. Kitui et al., (2008/2009) and Anyait and Mukanga (2012), postulated that if health facility

deliveries were beyond the means of women in low socio-economic status, the proposition of such women would be to deliver at home. Anyait and Mukanga (2012) and Gabrysch and Campbell (2009) share similar views that, previous obstetric complications and previous difficulty deliveries are strong pointers that a pregnant woman who had undergone the same, would seek professional help during the time of delivery. These researchers came to these conclusions based on their findings as discussed earlier in this study.

**Previous safe deliveries;** some women are likely to seek assistance from medical professionals only when they realize that they are in danger of losing their lives. This attitude may have been created from their previous delivery experiences where they gave birth without any problem. They may anticipate that all pregnancies are the same (Kibaru et al., 2006).

Other reasons for none access of maternal health care services are related to **cultural beliefs and practice**. Some cultures view pregnancy as a normal process and therefore a woman does not require any medical intervention. Actually in some communities any complication related to delivery and especially obstructed labour is associated with sinfulness of the woman (Kibaru et al., 2006). In the same cultural context, the Luhyas for example, believe that when a woman gives birth in a health facility she is likely to become barren because the rituals associated with the placenta which is a sacred organ cannot be performed in a hospital environment. The implication of such a belief is to dissuade pregnant women from giving birth in a health facility (ibid).

In rural Kenya some of the aspects that may also add to low usage of maternal health care services include poor sensitization of pregnant women to the importance of being assisted by a professional health care provider during delivery. This importance of the role of professional health care providers has been diminished by the function played by TBAs who

are appreciated in their communities (Cotter, Hawken & Temmerman, 2006). On the same note, these authors also point out that, some pregnant women view health facility as a harsh place for childbirth and they opt to deliver at home assisted by a traditional birth attendant.

As established by Novick (2010), choice of place of delivering the baby depended on **experiences of women** and the options they made either to give birth in a health facility or at home. Novick (2010) explored views and experiences of pregnant women regarding mother and child health care services. The researcher targeted USA African Americans. Novick's study revealed that some of the pregnant women preferred to give birth in a health because of the humane treatment they received from the medical health care providers. The women claimed to have been treated with respect coupled with comprehensive individualized care. However, majority of other pregnant women were purportedly to have been harshly treated, rushed and not listened to by the professional health care providers and therefore they preferred to give birth at home.

Exploring what deterred pregnant women from accessing maternal health services, researchers have come up with different results. For instance, Novick (2010) carried out a research which indicated that health care providers had negative attitude towards pregnant women which prevented them from accessing maternal health care services. These negative experiences according to the women included; inadequate information about likely complications that could occur during labour and communication barriers due to complicated medical jargons especially for pregnant women with lower literacy levels. In another research, Rahmani and Brekke (2013) explored how antenatal women and health care providers viewed the offered antenatal care services in Afghanistan with a view of establishing what influences pregnant women's selection of place of delivering their babies. The researchers used semi structured interview guides. The interviews were conducted in Kabul, Ramak village in Ghazni Province where 27 people were interviewed. These included

12 mothers who had recently delivered, 7 doctors, 5 midwives and 3 TBAs. The study revealed that pregnant women reported significant displeasure with the manner and behaviours of nurses, which included instances of verbal and corporal abuse. Roro and Hassen (2014) came to the same conclusion that negative attitude by health care providers towards pregnant women dissuaded them from choosing to deliver in a health facility.

From the preceding discussion it can be concluded that antenatal women who were attended to with respect in the health facility were likely to give birth in the facility. The converse is true that pregnant women treated with disrespect in health facilities opted to deliver at home where they were appreciated.

### **2.3.3 Literature Gap**

Research findings by Novick (2010) indicated that, women attempted to talk about their experiences in relation to quality of maternal health care services but the author felt that this needed to be verified. This was so because the author used only secondary data to arrive at the conclusion. Again drawing from the empirical literature discussed so far, it was observable that the researchers therein focused their investigations on quality of maternal health care services which was their objective. However a gap existed because pregnant women were not given chance to discuss where they were planning to deliver their babies and what would influence their choice. Besides, no follow up was made to ascertain where the pregnant women eventually delivered their babies. This study therefore filled up these gaps by documenting views of pregnant women in Kitui West Sub-county who were in their third trimester of pregnancy about their preference of where to deliver their babies and the reasons attributed to their choice. Qualitative work in this study where pregnant women were directly talked to, was beneficial to them. The consequent follow up made, ascertained where the women eventually delivered their babies and what factors influenced their choice.

In order to understand the perspectives of the respondents regarding what determined where they would deliver their babies and the reasons thereof, informed by theory, the researcher adapted Andersen (1995) framework as a basis within which to understand the above issues.

## **2.4 Conceptual Framework**

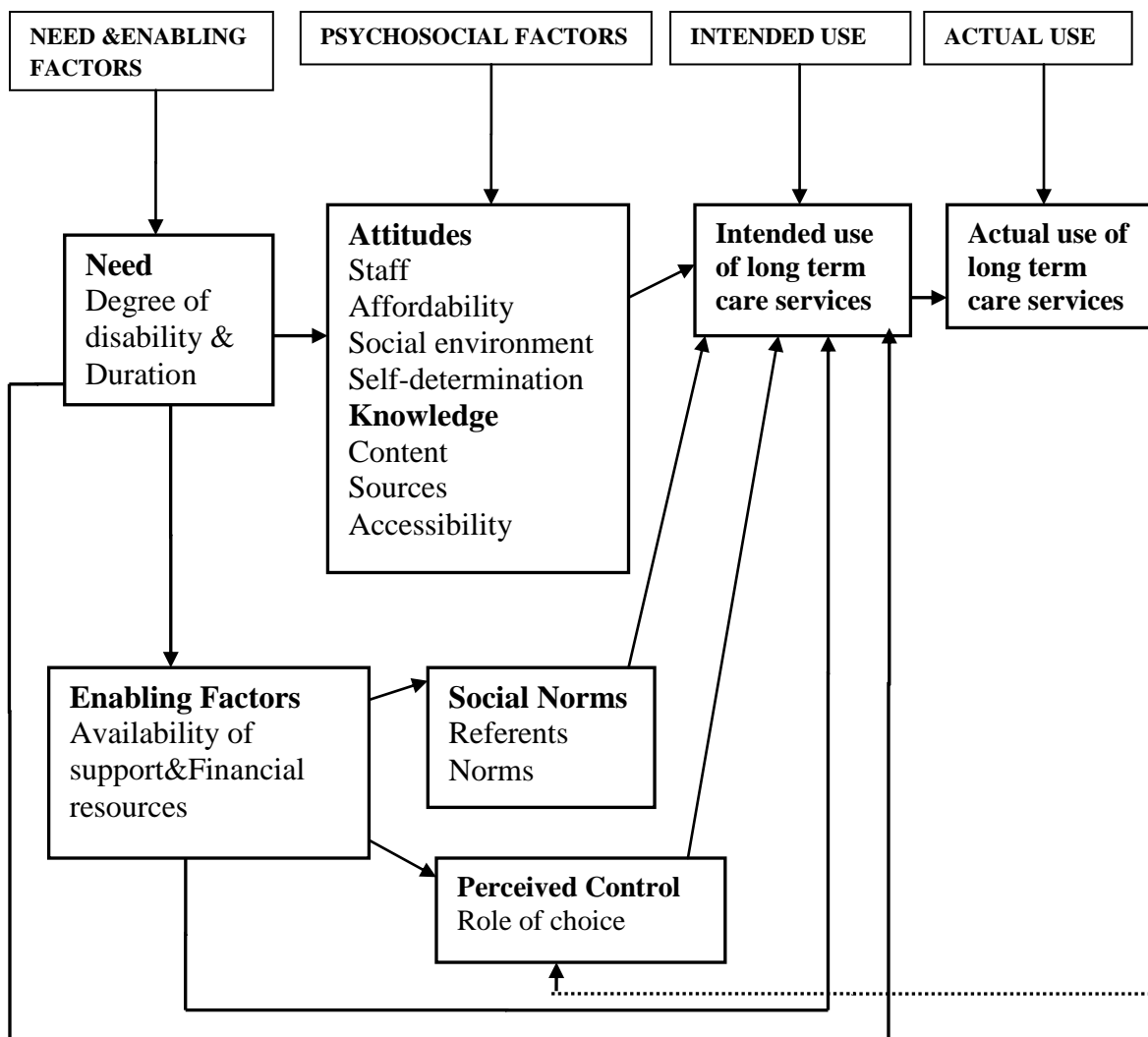
According to Kombo & Tromp (2009), conceptual framework is key to any research work because it guides the researcher to remain on track by connecting literature reviewed to the goals and objectives of the research. *The health utilization model, which guided this study*, demonstrates factors that precede utilization of health care services (Andersen 1995). In reference to this model, access to health care services is influenced by predisposing factors, enabling factors and need. Predisposing factors include race, age, and health beliefs. Enabling factors could be family support, access to health insurance, one's community. A need represents both perceived and actual need for health care services. Andersen's (1995) concept of predisposing factors on health care utilization is in tandem with the conceptualization of this study since the research endeavored to explore what influenced pregnant women in choosing their place of delivery. According to Andersen (1995), usage of health care services depends on demographic factors such as age and race. This study which also considered demographic factors included the following aspects; religion, marital status, level of education, age, occupation and previous number of births which were likely to determine where pregnant women had planned to deliver their babies.

Another determinant of utilization of health care services as pointed out by Andersen (1995) is related to distance to the health facility. In the case of this study, the aspect of accessibility in the form of distances to health facilities and availability of medical staff and their attitude towards the pregnant women were also considered. Andersen (1995) further concedes that an individual can afford to pay for health care services when family members



are supportive and financial resources are available. In the context of this study, being able to afford health care services would entail availability of personal resources of the pregnant woman, or support in terms of finances and suggestions from family members. All these aspects are likely to influence pregnant women's choice of place of delivery.

According to the model of health care utilization by Andersen (1995), social environment and social norm, knowledge, self determination and attitude of professional staff are other aspects that influence utilization of health services. In this study, social environment and social norm would imply support by significant others towards the pregnant woman, according to their cultural norms and practice which may influence where to deliver the baby. As well, the awareness of knowledge of pregnant women regarding complications associated with childbirth is likely to influence the pregnant woman to have self determination in choosing her place of delivering the baby. The need to access health care services is also emphasized by Andersen (1995) who postulates that, to see the need to utilize health care services, is determined by the severity of the condition and duration an individual has suffered. Figure 2.2 on page 37 helps to illustrate *behavioral model and access to medical care*.



**Figure 2.2:** Predisposing Factors on Health Care Utilization

**Source:** Andersen, R. M. (1995). Health care Utilization Model. *Health Social Behaviour*, 36(1), 1.

The interpretation of the above model is that; the need to utilize health care services will depend on the severity of the condition an individual is suffering from and for how long the person has suffered from this condition. Besides, for the individual to utilize health care services, there should be an element of support from *family members which could be* financial or any other factor such as social concern depending on the situation. In addition, the health care providers should have unconditional positive attitude towards those receiving the health care service. The individuals who access health care services are expected to be aware of the benefits accruing from such services. Nonetheless, if such individuals are

unaware of the advantages from such services, then they may be unmotivated to utilize the same. Determination of usage of health care services is viewed to stem from perception of an individual. Finally, health care services are of use to those receiving them if they are accessible and recipients of the services are determined to use them.

#### **2.4.1 Operational Framework**

From the model by Andersen (1995), on page 24, it is observable that the author's concept correlates well with the current study since the research endeavored to explore what influenced pregnant women in choosing their place of delivery. This being the case, the operational framework of this study based on the above was developed as shown in Figure 2.3 on page 39.

Predisposing Factors

<b>DEMOGRAPHIC FACTORS:</b> -Age -Level of education -Religion -Marital status -No. of children born, place & reason -No. of children dead, place of birth & cause of death -Occupation-nature of work	<b>CULTURAL BELIEFS AND PRACTICE:</b> -Attitude towards pregnancy and childbirth	<b>ROLE PLAYED BY OTHERS IN CHOOSING PLACE OF DELIVERY:</b> -Husband -In-laws -Parents	<b>PREGNANT WOMAN'S DETERMINATION IN USE OF HEALTH CARE SERVICES:</b> -Readiness to give birth in a health facility	<b>PERSPECTIVES OF PREGNANT WOMEN TOWARDS PROFESSIONAL HEALTH CARE PROVIDERS: -</b>  -Supportive -Non supportive
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Intervening Variables

<b>KNOWLEDGE OF AWARENESS:</b> -Woman's complications during childbirth -Baby's complications during childbirth -Awareness of advantages of delivering in a health facility	<b>ACCESS TO HEALTH FACILITY:</b> -Distance -Road networks -Transport	<b>LEVEL OF INCOME:</b> -Affordability of services	<b>PREGNANT WOMAN'S PAST EXPERIENCES:</b> -Previous history of childbirth	<b>SEX:</b> Sex of baby -Male -Female
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<b>PLACE OF DELIVERY OF THE BABIES</b> -No. of children born in health facilities -No. of children born at home
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**Figure 2.3:** Background Factors On Health Care Utilization

Adopted and modified from Andersen (1995)

The independent and intervening variables in the operational framework are likely to influence pregnant women's choice of place of delivery. These variables were measured to establish their effect on the choice of place of delivery by pregnant women in Kitui West Sub-county as shown in the methodology chapter that follows.

## **2.5 Research Hypothesis**

In this study, the key hypothesis that was considered stated that: The level of pregnant women's knowledge concerning advantages of giving birth in a health facility assisted by a professional health care provider in Kitui West Sub-county, was positively related to the women's choice of place of delivery.

## **2.6 Summary**

Chapter 2 reviewed literature that informed the study about the topic. This included; HBM, Model of Health Care Utilization, Autonomy Theory, Other Theoretical Perspectives Influencing Choice of Place of Delivery and literature gap. The chapter also discussed the conceptual and the operational frameworks.

### **3.0 CHAPTER THREE: RESEARCH METHODOLOGY**

#### **3.1 Introduction**

In this chapter, the researcher discusses the study area, source of data, research design, target population, sampling technique applied and research instruments. The chapter also examines, the training of field assistants, testing for validity and reliability of the research instruments, procedures for data collection, data analysis and ethical considerations.

#### **3.2 Study Site**

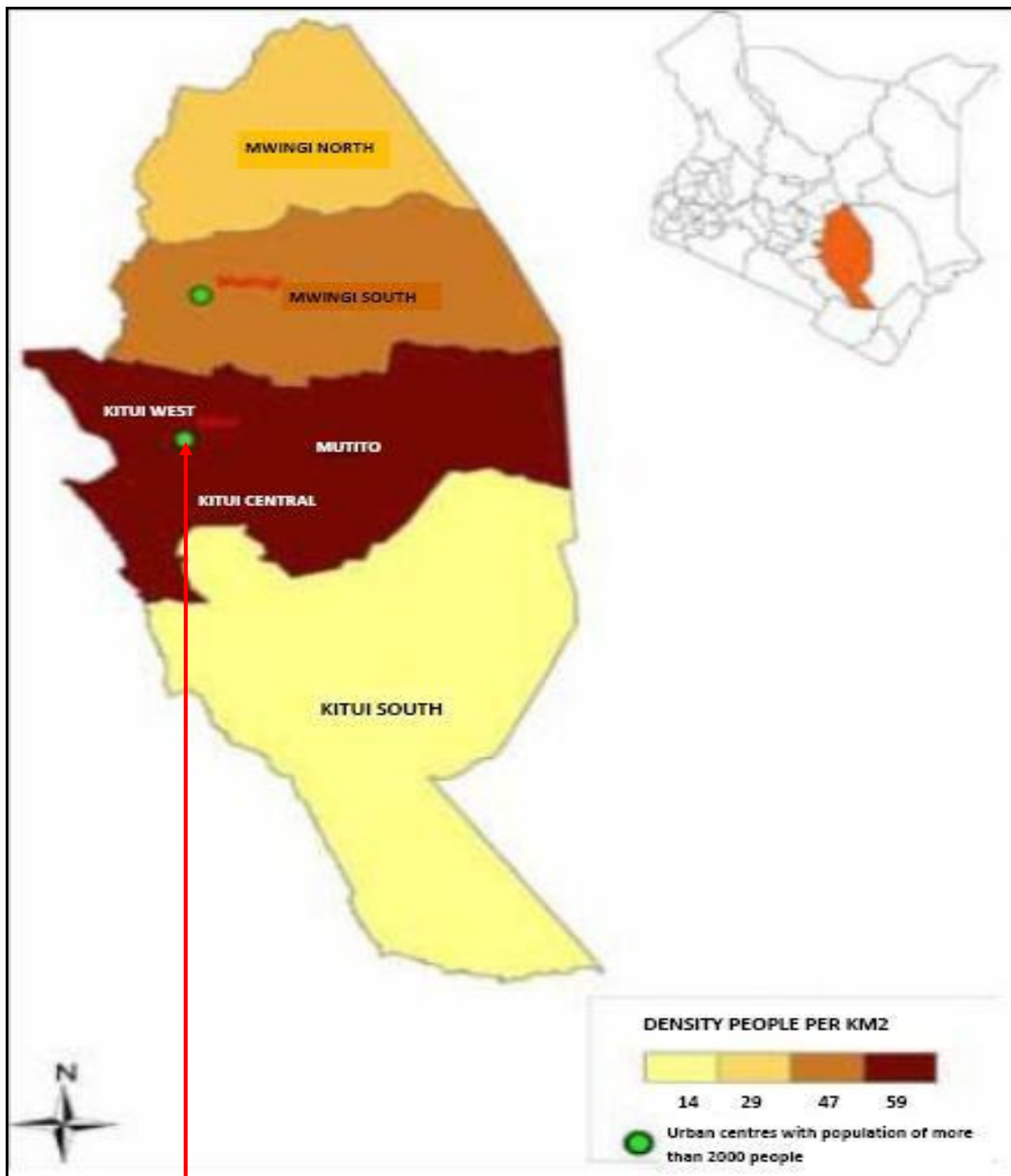
Kitui County is in the Eastern part of Kenya. The county shares common borders with Machakos and Makueni counties to the West, Tana River County to the East and Taita - Taveta County to the South. Kitui County covers an area of approximately 20,555.74 square kilometers. According to the 2009 Census, the county had a population of 1,012,709, comprising [481,282(48 percent) male], and [531,427(52 percent) female] (KNBS & ICF Macro, 2009). The county's average population density was about 47 persons/km<sup>2</sup>. The least populated area was Kitui East at 26 persons/km<sup>2</sup> and the most densely populated, Kitui Central at 220 persons/km<sup>2</sup> (See the map of Kitui in Appendix 8, page 175). The map also shows the position of Kitui West Sub-county, the study site. Kitui town, the county headquarters is about 200 kilometers from Nairobi. The inhabitants of the county are predominantly the Akamba ethnic group, majority being Christians (Nyasato, 2015).

According to Kitui County Development Strategic Plans (2013-2017), the rainfall is very unreliable making the county arid and semi-arid. The soil is usually low in natural fertility since it is sedimentary and red sandy soil. The high rate of evaporation, combined with unreliable rainfall, limit intensive and meaningful use of the land and other income generating activities (IGAs). Agriculture that could sustain a good population of Kitui is practiced on small scale due to harsh climatic conditions. Two percent of the county that is of

high potential is in the Central and Kitui West sub-counties. These zones are invariably highly populated. Cash crop such as cotton, which used to boost the economic status of the people, is no longer grown since there is no processing plant. The one that used to operate in the area was transferred to Kisumu. Horticulture, which could be a cornerstone of the domestic economy, can only be practiced under rain fed conditions but these conditions do not exist in most parts of Kitui. Most of the rivers in Kitui are seasonal. As an activity such as horticulture, cannot be sustained. Dams and pans (hollows in the ground that hold water for a short period of time) scattered throughout the district do not provide sufficient water to meet the local needs. Most of these dams and pans dry up very fast often due to prolonged drought and as such, this situation rules out the possibility of carrying out horticulture through irrigation. The county normally experiences food deficit due to recurring drought which hits most of the county especially the eastern, southern and northern parts. Food security in the county has been bad as consumers depend on outside support, which is sometimes expensive (Development Strategic Plans, Kitui County, 2013-2017).

Kitui County comprises of 16 administrative sub-counties. Health facilities are 261 with 3 County hospitals and 8 Sub-county hospitals. The main churches are; Pentecostal, Catholic, African Inland Church (AIC) and Anglican Church of Kenya (ACK). Kitui West Sub-county's total population was 102,314 with 17 health facilities. Only 8 of these facilities offer integrated health care services (immunization, antenatal care including delivery and curative services); the rest are owned by individuals and do not offer maternal health care services (Nyasato, 2015). Although Nyasato (2015) indicates that there are 17 health facilities and only 8 offer integrated health care services, the DPHN, Kitui West Sub-county, indicated that Kitui West Sub-county had 22 health facilities at the time of this study. Out of these facilities, 18 offered integrated maternal health care services that qualified for the selection of this study. The particulars about health facilities in Kitui West Sub-county were recorded

during the interview between the DPHN and the researcher on November 11<sup>th</sup>, 2016. The Kitui map on page 43 below indicates the study site.



Study Area (site)

Figure 3.4: Kitui County Map



### **3.3 Research Design**

The researcher mainly used qualitative research design because the study was explanatory in nature. It sought to get views and explanations from the respondents about what influenced their choice of place of delivery. Kombo and Tromp (2009) point out that qualitative research relies on a research plan that is flexible and interactive. By use of interactive approach, the researcher had the opportunity to create rapport with the respondents. For this reason, an in-depth sharing was feasible. On the same note, Kothari (2009) views research design as the arrangement of facts for data collection and its consequent analysis ensuring that the purpose of the study remains relevant to the objectives of the research. Oliver (2004) contributing to Kothari's (2009) assertion of what a research design is, considers research design as the practical elements of the way the research was done. Research design is the logic that links data to be collected with the conclusions to be drawn to the initial questions of the study (Cohen, Marion & Morrison, 2000). After delivery, data from postnatal women was collected mainly through oral testimonies using individual interview guide. The information was then analyzed and a conclusion was drawn based on the objectives of the study.

#### **3.3.1 Sample and Sampling Procedure**

The 10 health facilities out of the 18 with integrated health care services formed 56 percent of the 18 health facilities. The choice of 56 percent was guided by Mizner (2008) who points out that, sometimes a researcher uses his or her discretion to choose a higher sample size if it is envisaged that a smaller sample size may not yield enough data to explain a phenomenon. The process of selecting the 10 health facilities entailed simple random sampling whereby, names of the 18 health facilities were written on 18 small pieces of papers of same size then rolled into identical shapes and then mixed thoroughly. One of the trained

field assistants was asked to pick 10 pieces of papers randomly. The names of the health facilities picked became the sampled health facilities. The health facilities selected were; Kauwi, Matinyani, Kalimani, Iiani, Ndiuni, Katutu, Kwamulungu, Tulia, Maseki and Kauma. Oliver (2006) observes that in a simple random sample each member of the target population has equal chance of being selected. Bernard (1994) points out that, simple random sampling is much easier and more economical. Bernard (1994) further argues that complicated scientific methods of sampling are not needed in research where the subjects of inquiry are homogenous.

The calculation of the sample size of the pregnant women focused on the 2009 census which recorded the population of women at child-bearing age (15–49 years) as 1,230 in Kitui West Sub-County (KNBS & ICF Macro, 2009). To get the sample size, the calculation was;  $1,230 \times 15/100=184.5$ . Therefore, 185 pregnant women were to form the sample size for ANC- attendees. From each facility and its environs, the aim was to interview 19 pregnant women, arrived at by dividing  $185/10 = 18.5$ , rounded up = 19 pregnant women. Using the same formula of 15 percent, the number of pregnant women who were non-ANC-attendees was calculated, thus;  $19 \times 10 \times 15/100 = 28.5$ , rounded up = 30 pregnant women from the environs of the sampled health facilities. The choice of 15 percent sample size is backed by Mulwa (2008) who posits that 25 percent and below of a sample size is sufficient in order to avoid saturation of data. Therefore, 190 pregnant women were to be interviewed within the 10 health facilities; 160 from the 10 health facilities and 30 women who were not attending ANC were selected using snow-balling method from the environs of the randomly sampled facilities.

The researcher shared her research plan with the DPHN to the effect that she intended to collect data from 19 pregnant women within 7 and 9 months of gestation period (36 to 40 weeks), 16 from women who were ANC-attendees and 3 women who were non-attendees

within the environs of the sampled health facilities. In this connection, the DPHN pointed out that in some health facilities, it was not likely to get 16 respondents because some facilities were close to each other (radii of between 4 and 5 kms) and shared same catchment area. This was so because a pregnant woman could access maternal health care services anywhere so long as she had an ANC card. Moreover, the gestation period of focus in the study was a small segment of expectant women. The information prompted the researcher to enquire from medical records at the main health facility (Kauwi) on the number of pregnant women within the gestation period from 7 to 9 months attended to in each sampled health facility at the time. The records indicated that the required target group of 160 that is, 16 from each of the 10 health facilities could not be met. There were only 157 pregnant women within the stipulated gestation period. According to the records, some of the health facilities had less than 16 pregnant women within the required gestation period. Therefore, some health facilities such as Iiani, Matinyani, Kauwi and Ndiuni were oversampled because there were many ANC-attendees in these health facilities. This was done to compensate for the facilities that had less numbers in order to get the targeted figure of 157.

The number interviewed in each facility was: Iiani 19, Kauwi 18, Matinyani 18, Kalimani 17, Ndiuni 17, Kauma 16, Katutu 15 and Maseki 15. Therefore pregnant women interviewed in the 10 randomly sampled health facilities were 135. For pregnant women who were non-ANC-attendees, snowball technique was used to collect information from them. In this case, therefore, the researcher randomly identified some of the interviewed pregnant women who then identified 3 other pregnant women who did not access ANC services from each of the environs of the 10 randomly sampled health facilities to be interviewed. In total 30 pregnant women were interviewed from this category. In total, 165 pregnant women were interviewed – 135 women who were ANC-attendees and 30 non ANC-attendees. This latter group was considered as a control group in this study. Additionally, 2 FGDs were carried out

in Kwamulungu with 12 participants and in Tulia with 10 participants respectively. These 2 health facilities were considered appropriate for FGDs because there were only 12 and 10 pregnant women within the required gestation period. These discussions were held separately in each health facility. The objective of this discussion was to find out from the participants their perspectives on what influenced choice of place of delivery for pregnant women. For the respondents to feel comfortable and secure as they shared their experiences, the researcher liaised with the in-charge of the particular health facility where interviews were conducted to avail a private room within the facility.

Initially the researcher planned to hold 3 FGDs, 2 discussions with ANC-attendees at Kwamulungu and Tulia as indicated above and one with non-ANC-attendees. However, the intended FGD with the non-ANC-attendees was not possible because the women were reluctant to form a group. Later the researcher understood from the respondents that girls who dropped out of school because of pregnancy, unmarried pregnant women and pregnant women advanced in age were afraid to be seen pregnant by the rest of the community members because of stigma therefore they avoided any gathering. Guided by Mulwa's (2008) assertion that when a population is homogenous, a small group of respondents could be sufficient to avoid saturation of data, therefore the researcher considered the 2 sets of FGD as sufficient to inform the study.

Considering that the 10 sampled health facilities were managed by 10 nurses according to the DPHN, the researcher interviewed 5 nurses from these facilities. The names of the 10 health facilities were written on small pieces of papers and rolled into identical shapes and mixed thoroughly. One of the field assistants picked 5 pieces of those papers. The following health facilities were picked.

Maseki, Kauwi, Katutu, Ndiuni and Kalimani. The nurses from the 5 sampled health facilities represented by 50 percent were sufficient sample size. Mizner (2008) backs this view, contending that when a sample is small, the researcher can use his/her discretion to pick a higher number of respondents in order to get substantial results.

After selecting the nurses from the above 5 health facilities, simple random sampling was used to identify TBAs to be interviewed. Simple random sampling was used because it is advantageous; it gives each respondent equal chance to be selected to participate in the study (Bernard, 1994). The 2 CHVs who were attached to the 10 randomly sampled health facilities were requested to bring names of TBAs within the environs of the health facilities. In total 12 names of TBAs were presented to the researcher. Each name was written on a small piece of paper, rolled into same size, mixed thoroughly and randomly one of the research field assistants picked 8 names that represented 66 percent of this group. Picking a high number of respondents is beneficial because it has varied views (Mizner, 2008).

Before embarking on data collection exercise, the researcher trained 2 field assistants for 3 days (28<sup>th</sup>-30<sup>th</sup> December 2016). The field assistants who were trained included one retired nurse and one community development officer, both familiar with the environment of the area of the study. The researcher worked with the retired nurse instead of current staff based in the health facilities to make the respondents feel free to share their experiences without fear of victimization.

The areas of training included; translating the interview guide questions into Kikamba language, interviewing techniques, understanding the content of the tools, practicing how to interview to increase self-confidence in asking questions. After this exercise, a pretesting of validity and reliability of the instruments was carried out from 5<sup>th</sup> to 8<sup>th</sup> January 2017 in various health facilities.

Pretesting of the research instruments in respect of the ANC-attendees and non-attendees including FGDs was carried out at Kwamutonga health facility that was not among the 10 targeted health facilities. In this facility, 6 pregnant women within the required gestation period were interviewed individually. To pretest the research instrument for FGDs, 5 pregnant women participated in the discussion. To pretest research instruments for TBAs, 2 CHVs organized 4 TBAs around Kakeani area that was not one of the targeted health facilities, the research team interviewed them individually. To pretest the instruments for the nurses, the researcher liaised with the in charge of Muthale Mission Hospital where 6 nurses were interviewed. Muthale Mission Hospital was not one of the sampled health facilities.

The main objective of pre-testing the research instruments in this case was to ensure common understanding of the research instruments by the research team. The pretesting process gave the researcher an opportunity to establish if the questions therein elicited the required information. After pretesting the validity and reliability of the research instruments, necessary amendments were done. For instance, some questions were reframed to avoid ambiguous responses. Furthermore, some culturally sensitive words related to reproductive health were revised to enable participating respondents to unreservedly express their views. This was to ensure that the research instruments yielded the desired results. Validity according to Gray (2009) is observing and measuring the claims the researcher plans to measure by using research instruments consistently to collect data. Denscombe (2010) points out that, validity is the accuracy and precision of the data and appropriateness of the data in terms of the research question being investigated.

Reliability of an instrument on the other hand is the level of uniformity with which it measures the aspect it is supposed to measure; it seeks to establish whether a particular method applied repeatedly to the same object will yield the same outcome each time. Reliability of an instrument therefore refers to its accuracy and precision (Mugenda, 2008).

### **3.4 Data Collection Methods**

#### **3.4.1 Semi-Structured Interviews**

In-depth individual interview guide was used to gather data from 165 women during pregnancy and after delivery. Primary data was obtained from ANC-attendees in 10 of the randomly sampled health facilities in Kitui West Sub-county as discussed in the sample and sampling procedure on page 43. As the women came for ANC, those within the third trimester were purposely selected. This concurred with what Kombo and Tromp (2009) point out that, in purposive sampling, the researcher purposely targets a group of people believed to be suitable for the study. To complement purposive sampling, the researcher employed convenience sampling method. According to Kombo and Tromp (2009), this method entails meeting respondents haphazardly without prior sampling but according to the research objectives. Pregnant women who were non-ANC-Attendees, in the environs of the 10 randomly sampled health facilities were also interviewed using the same research instrument. This group was used as a control group to explore if they shared similar views regarding where pregnant women chose to deliver with ANC-attendees since they lived in the same community.

To get non-ANC-attendees within the targeted area, the researcher liaised with the interviewed respondents in the sampled health facilities in order to identify this category of pregnant women using snowball technique. The respondents who assisted in locating the others were chosen randomly to avoid bias. Each selected respondent was used as an informant to identify other pregnant women who were non-ANC-attendees. According to Cohen (2000), in snowball technique, researchers identify a small number of individuals who have the characteristics in which they are interested in. These people are used as informants to identify others who qualify for inclusion in the study.

The respondents who assisted to identify pregnant women, who were non-ANC-attendees, accompanied the research team to their homes. In other cases, the research team was given the contacts of the women to arrange a convenient day for the interview. The primary data regarding ANC and non-ANC-attendees focused on where the respondents planned to deliver their babies and the reasons for their choice of place of delivery. In-depth Individual interview guide was used as a method of data collection because it provided an opportunity for in-depth sharing. Kothari (2009) observes that individual interviews help to discover fundamental intentions and wishes.

The study focused on pregnant women who were in their third trimester (7-9 months gestation period). This was because these women were almost in the last trimester of pregnancy. Based on this understanding, the study expectation was that the decision of where the baby was to be delivered would have been made or was in the process of being made by this time.

### **3.4.2 Focus Group Discussions**

FGD was used to gather data from 2 groups comprising of 10 and 12 respondents. According to Cohen (2000), FGDs encourage introverted respondents to share their views as they see others sharing. Cohen (2000) further contends that FGD allows the researcher to change the flow regarding the way the questions are framed

### **3.4.3 Key Informant Interviews**

In-depth individual interview guide was used to gather data from five nurses in the 10 randomly sampled health facilities and eight TBAs within the environs of the same health facilities. The views of TBAs and nurses regarding choice of place of delivery by pregnant women were considered important because they accompany pregnant women from pregnancy to delivery. It was anticipated that this group would add more information to the study



beyond what the pregnant women would say during interviews. To gather information from nurses and TBAs, they were asked their opinion about pregnant women's choice of place of delivery. The nurse in charge of all the health facilities in Kitui West Sub-county was interviewed in her office. The other nurses were interviewed in their convenient places since the research team could not use health facilities as venues because nurses were on strike by then. The researcher visited TBAs in their respective homes through the assistance of CHVs.

The study was organized in 2 Phases-before and after delivery. The plan was to follow the same women who were interviewed at the ANC in the health facilities and its environs. The information regarding where they eventually delivered and the reasons for their choice of place of delivery formed Phase II of this study. After interviews, the respondents were followed up as they brought their babies for immunization to determine where they finally delivered their babies and what factors influenced their choice of place of delivery. The results of the follow up were important; they gave light regarding disparity between high attendance of 98 percent of ANC and unmatched health facility deliveries which stood at 61 percent in Kenya. Pseudonyms were given to ANC-attendees and non-attendees including TBAs to conceal their identity. Participants of FGDs were given letters, F1 to F22 while nurses were given N1 to N5. Majority of the respondents' responses were captured in verbatim

### **3.5 Data Processing and Analysis**

Data analysis was based on information gathered from ANC-attendees and non-attendees, nurses and TBAs. The data collected and analyzed focused on variables as indicated on page 33 under operational definition of variables.

The purpose of generating information based on the above variables was to find out if there was any association with the place where pregnant women chose to deliver their babies. Information from TBAs was in form of verbal testimonies, which aimed at capturing their views with respect to pregnant women's choice of place of delivery.

After data collection, the raw data was organized into a format that could easily be analyzed and make presentation feasible. Therefore, at this point the raw data was transcribed to make a meaning while emerging themes and patterns were identified, coded and categorized. In transcribing the raw data, the researcher scrutinized the information and picked the main idea by editing the information. To interpret the data, the researcher compared qualitative and quantitative data and identified common themes. According to Kothari (2009), data organization involves identification of errors and gaps that may influence the outcome of data analysis. In connection to what Kothari (2009) observes, it was during data organization process the researcher identified an omission relating to one of the variables namely occupation of the respondent. The research team went back to the field and filled this gap. This was done by checking the medical records from the randomly sampled health facilities for ANC-attendees.

The non-ANC-Attendees were visited in their respective homes. In this study, the researcher applied the Statistical Package of Social Sciences (SPSS) version 21, for converting numerical data derived from descriptive characteristics of respondents into pie charts and tables and analyzes frequencies. The Pie charts and tables summarized the profiles of the characteristics of respondents at a glance.

Cross tabulation and Chi- square test were used to explore if there was correlation between independent variables and dependent variable concerning preference of choice of place of delivering the baby for pregnant women. Significance level for statistical analysis was set at 95% ( $P \leq .05$ ) confidence level.

To analyze qualitative data, the researcher identified related concepts and grouped them into themes according to research questions. This was followed by the interpretation of the information given to explore the linkage and the analysis in relation to the objective of the study. The above approach of analyzing qualitative data by identifying concepts and themes was based on the idea of Oliver's (2006) postings that, to find out views on a certain issue from respondents, it is not always calculable by arithmetic associations. Oliver (2006) further contends that to analyze qualitative data, the researcher identifies themes that are relevant to the main research questions. In this study, the process of authenticating the research instruments was carried out through pretesting of the instruments as mentioned earlier. This was ensured through consistent use of the interview methods proposed, guided by the research objectives.

To ensure validity and reliability, the researcher made sure that respondents were asked the same question, consistently and accurately to ensure that validity and reliability were maintained at all times. The task of the researcher in the entire process of data collection was to supervise the field assistants to ensure that the procedures for data collection were adhered to in order to collect credible information. The other role was to discuss with the field assistants every morning prior to interviews to clarify any issues of concern and any gaps in recording the interviews. When the researcher realized that the research team was competent enough in data collection, she joined the research team in the process of data collection exercise.

### **3.6 Ethical Considerations**

The researcher obtained permission from AWSC before proceeding to obtain research permit from the National Commission for Science, Technology and Innovation (NACOSTI). She then proceeded to Kitui County for endorsement of the permit by the County Deputy Director of Medical Services and County Education Director. Finally the researcher was given a letter of authority to interact with the people on the ground by the County Commissioner.

The County Deputy Director of Medical Services introduced the researcher to the DPHN in charge of all the health facilities in Kitui West Sub-county was the area of study. Finally, DPHN in charge of Kitui West Sub-county health facilities gave her consent for the research to be conducted in the health facilities in Kitui West Sub-county.

The researcher ensured that she got verbal consent from the respondents before engaging them in data collection. She informed the respondents that the exercise was voluntary and that the purpose of the research was purely academic and that the findings therein might be published. They were made aware that the interview was focused on their experiences regarding their previous and current pregnancies. The respondents were assured that they would not be named in connection with the research; there would be no way in which the opinions they expressed could be associated with them personally. This was done by giving individual respondents corresponding numbers to conceal their identity. The respondents were offered the right to accept, refuse or to withdraw from the interview without fear of any form of intimidation.

The content which had been written during the interview was shared with the respondents to confirm if what was written was correct. On the other hand, the researcher was not deceptive by purporting to represent the research by what it was not. All cited literature was honored and acknowledged at all times to avoid plagiarism.

### **3.7 Summary**

This chapter focused on the methodology used in the study which included source of data, research design that highlighted how the research work was structured, target population, sample frame that guided the researcher in selection of the respondents and the health facilities to be included in the study. Also discussed were data collection instruments, training of field assistants to equip them with interview techniques.

Pretesting of validity and reliability was done to ensure authentic information was collected and procedures of data collection was systematic. Further, the chapter focussed on how the information was to be gathered and where, ethical considerations and lastly, how the data was to be analysed. The next chapter four, focused on data presentation and analysis so as to construct a meaning out of the raw data.

## **4.0 CHAPTER FOUR: CHOICE OF PLACE OF DELIVERY AMONG EXPECTANT WOMEN IN KITUI WEST SUB-COUNTY**

### **4.1 Introduction**

This chapter focuses on the findings of the study as per research objective one which was to explore from pregnant women their choice of place of delivery in Kitui West Sub-county and reasons for their choice. First, descriptive statistics of the pregnant women was presented. Second, the findings on women's perspectives on factors that they perceive influenced their choice of place of delivery followed. Finally, the reasons for the choices of where to give birth were discussed.

### **4.2 Descriptive Characteristics of ANC-Attendees and Non-Attendees**

This section provides results describing characteristics of the women who participated in the study as shown in table 4.2 on page 58. These characteristics included the gestation period of pregnancy, age, marital status, education level, occupation, previous deliveries, place of birth of previous births, status of previous births, women's experiences in childbirth and religion. Also, the representation of the results followed this sequence, but this does not imply any level of importance among the variables. The organization of the results in the table was provided for both the pregnant women who attended ANC and those who did not attend.

It should be noted that during the study, 37 percent (50) of ANC-attendees were expecting their first baby, therefore, the discussion of the results relating to the variable of **previous births** focused on the 85 respondents who had previously given birth out of 135 women who attended ANC. Likewise, 86.7 percent (26) of the women who did not attend ANC had previous deliveries and only 13.3 percent (4) were expecting their first baby.

Variables		ANC-attendees: N135		Non-attendees: N30	
	Categories	%age	No.	%age	No
Gestation period	7 months	32	43	20	6
	8 months	36	49	37	11
	9 months	32	43	43	13
Age	16-20-years	18	25	7	2
	21-25-years	42	57	20	6
	26-34-years	33	44	40	12
	35 & above years	7	9	33	10
Marital status	Married	78	105	83	25
	Unmarried	22	30	17	5
Education level	No schooling	0.7	1	-	-
	Primary	63.7	86	77	23
	Secondary	28.9	39	23	7
	Tertiary	6.7	9	-	-
Occupation	Teachers	43	58		
	No occupation	19	26	10	3
	Small businesses	16	21	57	17
	Subsistence farming	11	15	20	6
	Housewives	11	15	13	4
Previous deliveries	1 <sup>st</sup> pregnancy	37	50	10	4
	1 – 2 children	47	63	33	10
	3 – 5 children	15	20	47	13
	6 – 8 children	1	2	10	3
Place of birth of previous births	Home deliveries	37	60	91	81
	Health facility deliveries	63	104	9	8
Status of previous births - children who suffered -Children who did not suffer	Death	3.1	5	5.6	5
	Premature baby	1.2	2	2.3	2
	Swollen head			1.1	1
		95.7	157	91	81
Women's past experiences of childbirth	Complications	22	19	15	4
	No complications	78	66	85	22
Religion	Pentecostal churches	37	49	40	12
	Catholic	33	45	33	10
	AIC	30	41	27	8

**Table 4.2:** Descriptive Characteristics of ANC-Attendees and Non-Attendees

In this study, *gestation period* refers to the duration of pregnancy in human female up to delivery. As shown in table 4.2, majority (36 percent) of the ANC-attendees were in the 8<sup>th</sup> month gestation period while those in the 7<sup>th</sup> month gestation period were 32 percent and those in the 9<sup>th</sup> month of gestation period were 32 percent as well.

Regarding the non-ANC attendees, the majority (43 percent) of respondents were in the 9<sup>th</sup> month gestation period. Those within the 8<sup>th</sup> month gestation period were 37 percent. Respondents in the 7<sup>th</sup> month gestation period were 20 percent. The significance of dealing with women in their 3<sup>rd</sup> trimester (7<sup>th</sup>, 8<sup>th</sup> and 9<sup>th</sup> gestation period) was that at this point in time, it was expected that the pregnant women would have made decision on where to deliver their babies.

As regards to *age*, respondents in the age bracket between 16 and 20 years were 18 percent for ANC-attendees while those in the age bracket from 21 to 25 and who were the majority totaled to 42 percent as indicated in table 4.2 on page 58. Respondents who were between the ages of 26 and 34 were 33 percent. Respondents aged 35 and above were 7 percent. The respondents in the age bracket between 16 and 20 years from non-ANC-attendees were 27 percent while those in the age bracket between 21 and 25 were 20 percent. Respondents aged between 26 and 34 and who were the majority were 40 percent while those 35 and above were 33 percent. The age of respondents was grouped as guided by Levinson (1978) who divides age according to the experiences individuals undergo at each particular Phase of their lives. These phases are; childhood and adolescence up to 17 or 18 and ends at 22 years. Early adulthood begins from 22 to 35 years, above 35 years are grouped as middle adulthood. The first category (17-22 years) is supposed to be forming intimate relationships with others and they need to be guided on how to form meaningful relationships. An individual in the second and third phase (22 to 35 years and above), develops a career, thinks of starting a family, and engages in social enterprises (ibid).

Considering further the profiles of the ANC-attendees and guided by Levinson (1978) assertions regarding age, it was established that 16 out of the 25 respondents within the age bracket from 16 to 20 years were not married. The implication of this situation was that majority at 64 percent were under the custody of their parents. The fact of being under the



protection of parents was commensurate with what Levinson (1978) observes. The author contends that, such category of persons needed guidance. That could be the reason why 32 percent of the unmarried respondents in this group of 25 relied on their mothers to permit them to identify the place of delivery for their babies. On the other hand, out of the 30 non-ANC-attendees 40 percent between 36 and 24 years were married. According to Levinson (1978), this category of persons is supposed to be forming a family.

This explains why out of 85 respondents, 32 percent sought permission from their husbands while 17.2 percent sought permission from their mothers and a similar percentage sought permission from their mothers-in-law as illustrated in Table 4.5 on page 78. Analyzing the data still further, the study established that among the ANC-attendees aged 35 years and above had delivered 31 children and 68 percent of them were delivered at home while 32 percent were delivered in a health facility. Out of the 25 respondents in the age category between 16 and 20 years, 22 were expecting their first baby and their anticipated place of delivery was in a health facility. The remaining 3 respondents in this group had previously delivered all their 3 children in a health facility. Analyzing data for non-ANC-attendees, the same trend was observed whereby the aged pregnant women preferred to deliver at home whereas young pregnant women inclined to deliver in a health facility. For instance, it was observed that respondents in the age bracket between 21 and 25 had previously delivered 43 children and 81 percent of them were delivered in a health facility. Age bracket between 26 and 34, 33 children had been born by this group; 88 percent of them were delivered at home. Respondents aged 35 and above had 49 children and 96 percent of them were born at home. It could rightly be construed that respondents who were at their tender age and especially in their first pregnancy preferred to give birth in a health facility.

It was also observable from the analysis that, the category of 35 years and above preferred to give birth at home. Based on these findings, it could be concluded that age was relative to the high percentage of home deliveries. These observations suggest that, advancement in age was likely to influence women to give birth at home.

As pertains to *marital status*, 78 percent of ANC-attendees were married while those who were unmarried were 22 percent. Respondents who were between 17 and 22 years, 12 percent relied on their husbands to choose a place of delivery. Interestingly, a similar trend of relying on husbands to choose place of delivery for them was also observed in the age bracket from 26 to 34 years where 93 percent of them were married and 34 percent of them depended on their husbands regarding where they would deliver their babies. Compared to the non-ANC-attendees, married respondents were 83 percent while 17 percent were unmarried. Among the married respondents 44.5 percent relied on their mothers-in-law and 33.3 percent relied on their husbands to choose for them place of delivery as indicated on Table 4.5 on page 78.

Interestingly, as shown in the Chi-square test analysis; ( $\chi^2=6.036$ ;  $df=2$ ;  $p=0.049$  where  $p \leq 0.05$ , cf. appendix 7 p174) there was a weak relationship between marital status and preferred choice of place of delivering the baby. Further analysis of the Chi-square test indicated that married respondents who delivered at home were 5.8 percent and the unmarried respondents who delivered at home as well were 6.2, positing a small margin of 0.4. Another observed feature from the Chi-square test analysis was that a margin of 8 percent was maintained as more unmarried respondents were indecisive about where to deliver their babies. From the Chi- square test analysis, one percent of married respondents were uncertain about where to deliver their babies as compared to 9 percent of unmarried respondents who were undecided where to give birth.

Certainly, the findings of this study were in line with that of Daniels et al., (2013) that, marital status has a significant association with skilled birth attendant in that women who were married were more likely to seek professional assistance during childbirth. Daniels et al., (2013) were investigating which factors influence women to use maternal health services in Ghana.

Concerning the 30 non-ANC-attendees, the social descriptive characteristics of respondents (cf. Table 4.2 p58) showed that; 83 percent out of 30 non-ANC-attendees were married while 17 percent were unmarried. According to the Chi-square test analysis, marital status was not statistically significant for the non-ANC-Attendees ( $\chi^2=2.918$ ;  $df=2$ ;  $p=0.232$  where  $p \leq 0.05$ , cf. appendix 8 p175). This was so probably because 70 percent of the respondents according to this study made personal choices where to deliver their babies without influence from significant others. Thirty percent sought permission before choosing place of delivery (cf. figure 4.13 p79). The findings of the Chi-square test analysis were in agreement with other studies from Ethiopia and Uganda carried out by Assfaw and Sebastian (2010) and Anyait et al., (2012), who confirmed that marital status did not influence place of delivery. Assfaw and Sebastian (2010) researched on ‘Determinants of Antenatal Care, Institutional Delivery and Skilled Birth Attendant Utilization’ in Samre Saharti District, Tigray, Ethiopia while Anyait, Mukanga, Oundo, and Nuwaha (2012), examined in Busia district of Uganda, what motivates women to deliver in a health facility.

Concerning *education level* and as shown in Table 4.2 on page 58, it is clear that 63.7 percent of ANC- attendees had attained primary education while 28.9 percent had secondary level of education; 6.7 percent attained tertiary level of education while 0.7 percent of the respondents did not have school based education. Interestingly, the educational level of respondents in this age bracket of between 16 years and 20 years was low. For instance, 63.7 percent had attained primary level of education and perceiving issues pertaining to maternal health care

which was transmitted in English, could thus be a challenge for them to internalize. Surprisingly, information related to issues about childbirth was contained in booklets written in English and supplied to pregnant women as they attended ANC. These women were expected to read and understand the contents therein which was expected to influence them to deliver in a health facility.

Although Wolelie et al., (2015) regard level of education as a crucial aspect in the utilization of maternal health services, this study found no statistical significance between level of education and choice of place of delivering the baby; as attested by Chi-square ( $\chi^2=0.617$ ;  $df=4$ ;  $p=0.961$  where  $p \leq 0.05$ , cf. appendix 7 p174). More information from the Chi-square test analysis revealed that respondents with primary or secondary level of education seemed to act in the same way regarding where to deliver their babies. For instance, according to the Chi-square test analysis, 91 percent, 89 percent and 92 percent of respondents with no formal education, primary, secondary and above level of education respectively, delivered their previous children in a health facility while 6 percent in all the categories delivered at home. These results were not in tandem with those of Woldemicael (2007) and Teferra et al., (2012) who contended that there was a positive association between maternal education and place of giving birth. These researchers were exploring if women with higher education accessed maternal health-care services more than women with lower education in Sekela District, North West of Ethiopia.

Out of the 30 non-ANC-attendees, 77 percent had attained primary level of education and only 23 percent had attained secondary school education. The Chi-square test analysis regarding the 30 non-ANC-attendees in relation to the level of education indicated that there was no association between level of education and place of birth as indicated in the Chi-square test analysis ( $\chi^2=4.612$ ;  $df=4$ ;  $p=0.330$  where  $p \leq 0.05$ , cf. appendix 8 p175). Further Chi-square test analysis showed that respondents with primary level of education (62 percent)

tended to deliver their children at home whereas a higher percentage of those with secondary school education, 71 percent delivered their children at home as well. These results contradicted with the findings of Woldemicael (2007) and Teferra et al., (2012) as discussed above. The study expected that majority of respondents who had higher level of education would prefer to give birth in a health facility because probably they were more enlightened on issues of childbirth. Contrary to the expectations of this study, educated respondents seemed not to have been influenced by education.

In the *occupation category* in Table 4.2 on page 58, 43 percent of ANC-attendees were teachers while 19 percent did not have any occupation since they were school dropped outs. Sixteen percent had small businesses and 11 percent practiced subsistence farming. Eleven percent of the respondents were housewives and were not particularly involved in any other form of occupation. Fifty seven percent of the respondents from non-ANC-Attendees owned small businesses, 20 percent practiced subsistence farming, while 13 percent of them were house regarding occupation wives. Ten percent 10 percent did not have any occupation. The question regarding occupation sought to find out if the nature of work of respondents influenced where they had planned to give birth. Both categories of ANC-attendees and non-ANC-attendees indicated that occupation did not influence their choice of place of delivery.

*Previous deliveries* as shown in Table 4.2 indicate that, 46 percent of the ANC-attendees, were in their first pregnancy. Respondents who had 1-2 children were 47 percent, those with 3-5 children were 15 percent and with 6-8 children were 1 percent. For non-ANC-attendees, 10 percent were in their first pregnancy, 1-2 children, 33 percent, 3-5 children 47 percent and 6-8 children were 10 percent.

As far as *place of birth of previous births* is concerned, it is clear that from table 4.2 that 37 percent of ANC-attendees had previous births delivered at home. The rest of the children; 63 percent and who were the majority were born in various health facilities. Out of 85 ANC-attendees who had previously given birth, 50 of them delivered all their previous children in a health facility.

The respondents gave various reasons for delivering in a health facility. For instance, 46.9 percent were afraid of complications likely to occur during childbirth, while 16.0 percent were attracted by the care given by nurses. Some of the respondents (8.6 percent) chose to deliver in a health facility because of the safety of mother and baby. Another 7.4 percent of the 50 respondents chose to deliver in a health facility because they suffered previous complications and did not want to take chances by delivering at home while 5.0 percent among the 50 respondents chose to deliver in a health facility in case of breech presentation. Out of the 50 respondents, 3.7 percent of them delivered in a health facility in case the baby swallowed amniotic fluids during delivery while 3.7 percent were advised by the nurse to deliver in a health facility. A further 3.7 percent delivered in a health facility because they were afraid of witchcraft if they delivered at home. Another 2.5 percent, and 6.2 percent, gave various reasons which included; encouragement by a husband and a grandmother, maternity services being free and a need to be examined thoroughly to determine the type of delivery anticipated. The 25 ANC-attendees, who delivered some of their children in a health facility and others at home, delivered in a health facility in case of complications. Fifty percent of them hoped to take advantage of care given by nurses, 26.7 percent others were encouraged by husbands to deliver in a health facility while 10 percent were referred by TBAs to health facility. The nurse advised 6.7 percent of the 25 ANC-attendees to deliver in a health facility citing different reasons while 3.3 percent out of the 25 respondents had prior childbirth complications and did not want to risk by delivering at home.

The twenty five respondents out of 85 ANC-attendees delivered some of their children at home and gave the following reasons; 16 percent were assured by the TBA that delivery was possible at home. Twelve percent were encouraged by significant others who included a father of one of the unmarried respondents, a mother-in-law and family members of one of the respondents. Eight percent had safe previous deliveries and for them, they did not see the need of delivering in a health facility. Other eight percent had no money for transport to the health facility. Fifty six percent did not give reasons why they delivered at home. Ten respondents out of 85 ANC-attendees delivered all their children totaling to 24 at home. Fifty percent of the 10 ANC-attendees delivered all their children at home because of previous safe deliveries. Twenty percent of them were encouraged by their mothers and TBAs while 30 percent did not give reasons why they delivered all their children at home.

For the non-ANC-attendees, the information regarding where previous children were delivered and the experiences during childbirth helped to determine whether choice of place of delivery was influenced by the factors cited by the ANC-attendees. As discussed earlier in this study, 13.3 percent of the non-ANC-attendees were expecting their first baby and therefore only 86.7 percent respondents indicated where they delivered their previous children. These respondents delivered 89 children and 91 percent of these children were delivered at home. A small number at 9 percent were born in a health facility. A significant number 46.2 percent out of the respondents said they delivered their previous children at home because they had not experienced any complications related to childbirth. Some of the respondents (7.69 percent) stated that their husbands insisted that they should deliver at home. And another, 7.69 percent of the respondents pointed out that their mothers-in-law encouraged them to deliver at home while one (3.84 percent) respondent was prevailed upon by her grandmother to deliver at home.

Furthermore, about 23percent of respondents gave 6 reasons each citing their views as follows; “Hospitals are for referrals when a woman is unable to deliver at home”, “I am too old to be assisted by young midwives in the health facility”, “So long as normal delivery is possible at home, to deliver at home is the preferred choice”, “I feel safe in the hands of a TBA”, “I have no money to hire a vehicle to take me to a health facility”, “I just decided to give birth at home”. Other 11.54 percent did not give reasons for delivering their children at home.

Surprisingly, as indicated in table 4.2 on page 58, the respondents who bore largest number of children preferred to deliver at home despite the fact that 70 percent of them chose where to deliver their babies on their own accord. From oral interviews six out of 26 respondents delivered some of their children in a health facility and others at home. Two respondents were transferred by TBAs to a health facility because they could not deliver at home. One respondent was advised by the nurse to deliver in a health facility while another was encouraged by her parents. Another respondent delivered in a health facility after excessive bleeding. The last respondent among the 6 did not give any reasons for delivering in a health facility.

**Status of previous births**, during delivery some of the babies suffered and others died as indicated in table 4.2 on page 58. According to the 85 ANC-attendees who had a previous birth, it is noted that of the 164 babies that they had, only 2 percent of the children suffered during childbirth. The complications experienced were death of one baby, one baby suffered from fetal distress. One was born through caesarean section and did not cry immediately after birth but it survived. Out of 89 children born by the non-ANC-attendees who had previous births, 1.1 percent of babies were born with swollen head while 2.2 percent died at home being assisted by a TBA. Twice as many babies of those born at home suffered and died.



The study viewed *women's past experiences in childbirth* as a precursor to determining if childbirth experiences influenced choice of place of delivery of respondents. Out of ANC-attendees who had experience of childbirth, 22 percent experienced various complications during previous childbirth while 78 percent did not.

The complications experienced by respondents included; 63.2 percent prolonged labour before birth, 26.3 percent experienced; bleeding , high blood pressure with bleeding, breech presentation and irregular labor pains all before birth while 10.5 percent of respondents experienced vomiting and retained placenta after birth.

Non-ANC-attendees also suffered during previous childbirth. The 26 respondents who had experience in childbirth, 75 percent experienced prolonged labour while 25 percent became anaemic after delivery because of excessive bleeding. For all respondents, prolonged labour was the highest complication they experienced. This was because the process of childbirth was initiated from home assisted by a TBA and the respondents were referred to a health facility when the TBA realized that delivery was not possible at home.

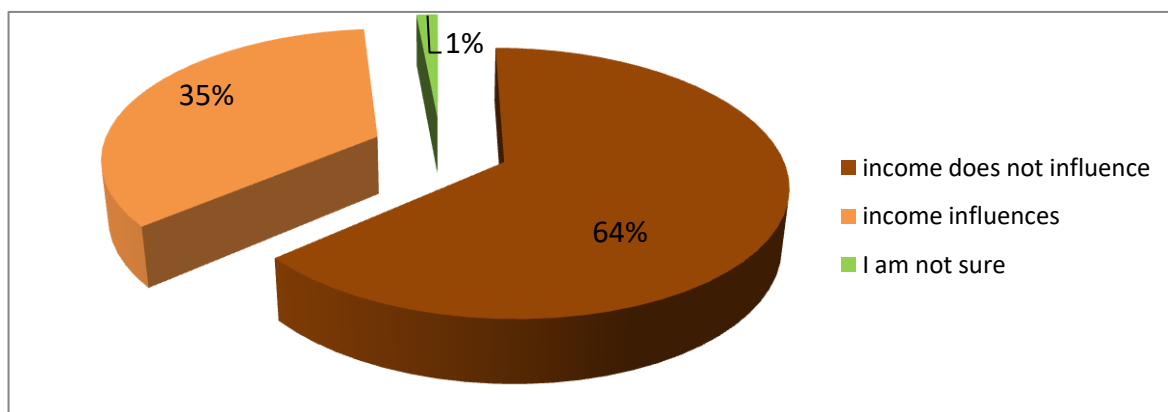
Regarding *religion* of the respondents, majority 40 percent of them belonged to Pentecostal churches followed by Catholics 33 percent and AIC with 27 percent. However from the qualitative data all the ANC-attendees indicated that their choice of place of delivery was not influenced by their religious beliefs and practice. Among the non-ANC-attendees, 93 percent were not influenced by their religious beliefs and practice. Nevertheless, 7 percent of non-ANC-attendees indicated that their religious beliefs and practice would influence their choice of place of delivery.

### 4.3 Perspectives of Women on Factors that May Influence Place of Delivery

This section focused on the perspectives of respondents regarding factors that may influence choice of place of delivery. This exploration aimed at establishing general views of respondents. These factors included; level of income, age, cultural beliefs and practice and access to health facility and focused on all the women rather than only those that had a previous childbirth.

#### 4.3.1 Pregnant Woman's Level of Income

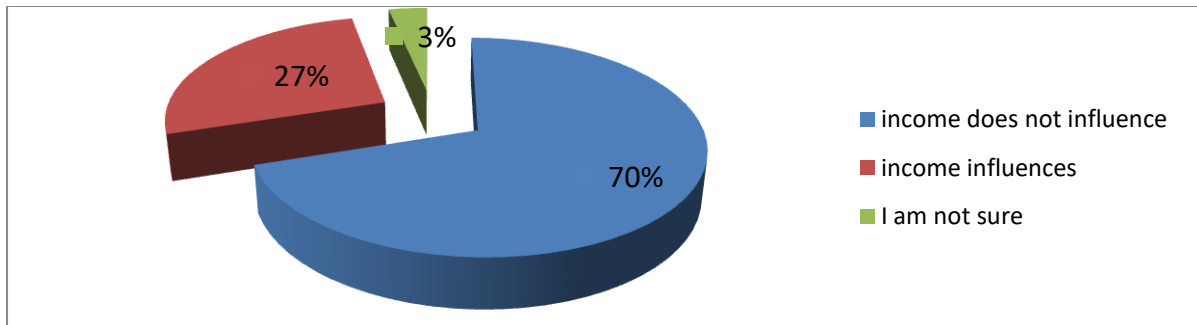
Focusing on the 135 ANC-attendees regarding whether giving birth at home or in a health facility depended on the level of income of the pregnant woman, 64 percent indicated that level of income of a pregnant woman did not influence choice of place of delivery. However, 35 percent were in agreement that level of income of a pregnant woman influenced her choice of place of delivering the baby. At the same time, 1 percent was unsure if the level of income of a pregnant woman had an impact on her choice of place of delivering the baby. Figure 4.5 below indicates the percentages for each category.



**Figure 4.5:** Responses on Influence of Income: ANC-Attendees

Focusing on the 30 non-ANC-Attendees regarding whether giving birth at home or in a health facility depended on the level of income of the pregnant woman, 70 percent of the

respondents said that level of income of a pregnant woman did not influence her preference for choice of her place of giving birth. Nonetheless, 27 percent of them maintained that level of income of a pregnant woman influenced her choice of delivery. Three percent of the respondents were not sure if the level of income of a pregnant woman had an impact on her choice of where to deliver her baby. Figure 4.6 below highlights these details.

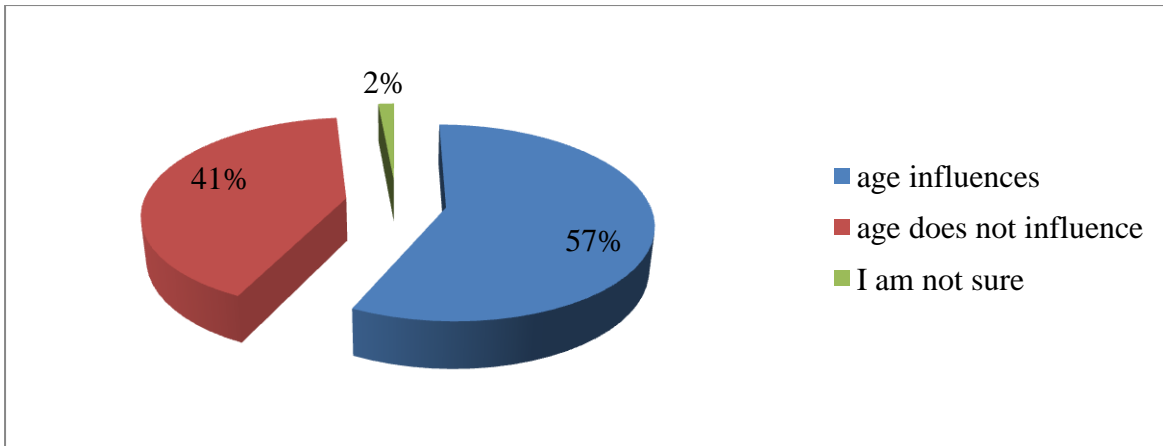


**Figure 4.6:** Responses on Influence of Income: Non-ANC-Attendees

Judging from the tabulations on figures 4.5 and 4.6, level of income seemed not to influence place of delivery for pregnant women. Having highlighted to what extent the level of income of a pregnant woman influenced her choice of place of delivering her baby, the next text explored from the respondents if age had any influence on choice of place of delivery.

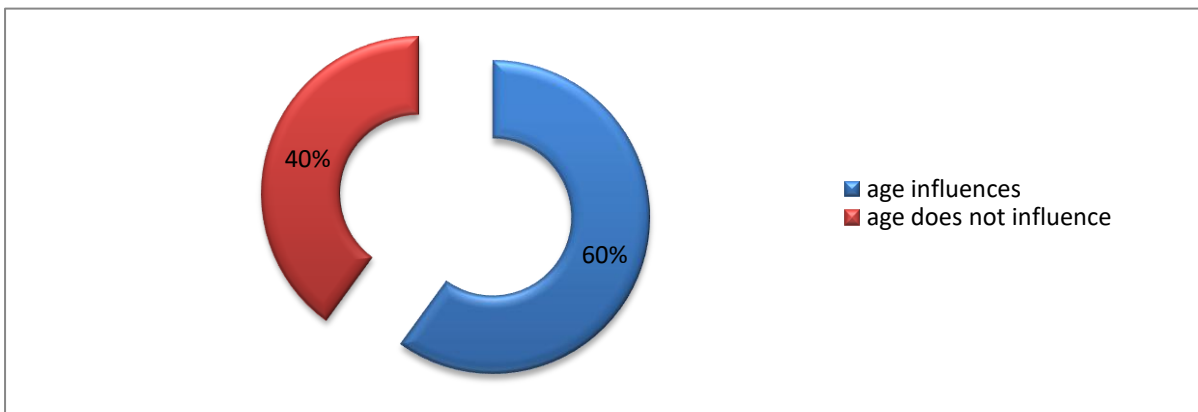
#### **4.3.2 Age and Choice of place of Delivery**

Fifty seven percent of 135 ANC-attendees said that age did not influence a pregnant woman's preferred place of giving birth while 41 percent indicated that a pregnant woman's age influenced her choice of place of giving birth. However, 2 percent of the respondents were not sure if age of a pregnant woman could influence her choice of place of delivering her baby or not. Responses on influence of age on choice of place of delivery were presented in Figure 4.7 on page 71.



**Figure 4.7:** Responses on Age and Choice of Place of Delivery: ANC-Attendees

The next discussion focused on responses from the 30 non-ANC-attendees. Sixty percent of them said age of a pregnant woman influenced the preferred place of giving birth. Nevertheless 40 percent maintained that age of a pregnant woman did not influence her preferred place of giving birth. The results of the responses are indicated in Figure 4.8 below.



**Figure 4.8:** Responses on Age and Choice of Place of Delivery: Non-ANC-Attendees

In reference to the results based on the women’s opinions in figures 4.7 and 4.8 above, place of giving birth was influenced by age for the 2 groups. Although the descriptive data analysis indicated that young women were more likely to deliver in a health facility, these results contradicted the verbal results from the respondents as seen in the foregoing discussion that young women were likely to deliver at home.

### **4.3.3 Cultural Beliefs and Practice and Place of Delivery**

Focusing on ANC-attendees, it was found that out of the 135 ANC-attendees, 96 percent contended that cultural beliefs and practice that would influence place of birth such as rituals associated with burying the placenta at home immediately after birth, did not in any way influence their choice of place of delivery. Anyhow, 4 percent of the respondents said that cultural beliefs and practice existed in their families and influenced their choice of place of where their babies would be born. On the other hand, 3.3 percent of the respondents among the 30 non-ANC-Attendees, their choice of place of delivery was influenced by their culture. The remaining 96.7 percent respondents conceded that their choice of place of delivering their babies was not affected by cultural beliefs and practice.

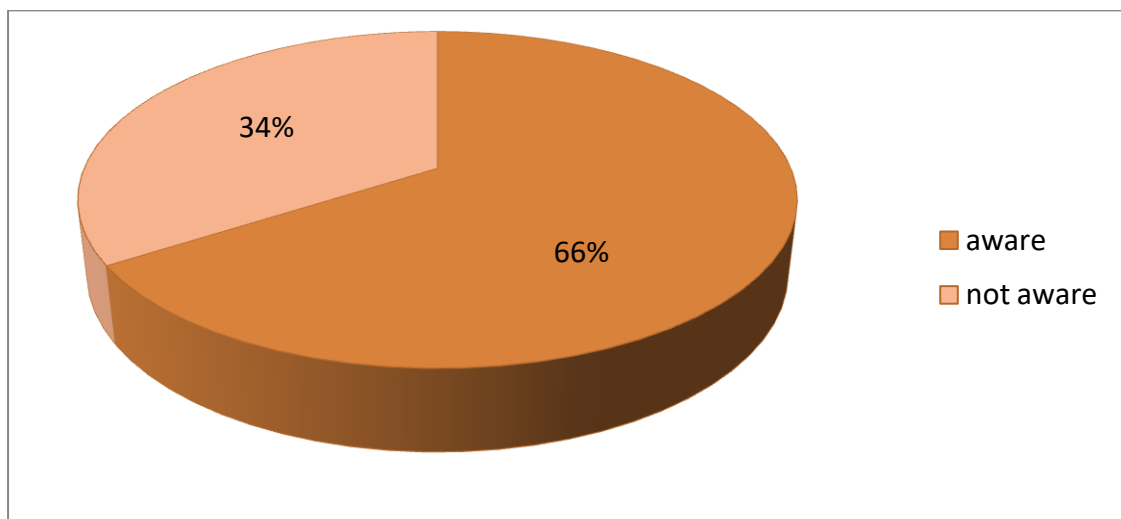
### **4.3.4 Access to Health Facility**

In respect to access to health facility, 99 percent of the 135 ANC-attendees said that road networks were good and there was good supply of public means and especially motorbikes from their homes to the respective health facilities. However, 1 percent of the respondents pointed out that they were far away from the health facilities which offered maternity services for 24 hours. On the other hand, 83 percent of the 30 non-ANC-attendees maintained that means of communication to access health facilities was not a problem because transport was available. Nonetheless, 10 percent of the respondents pointed out that means of transport could affect their choice of place of delivery. These respondents lived a bit far from the health facilities and road networks were poor. Seven percent of 30 respondents who had dropped out of school were not sure whether means of transport could influence choice of place of delivery because they depended on significant others for financial support.

#### 4.4 Awareness of Complications during Childbirth: ANC-Attendees

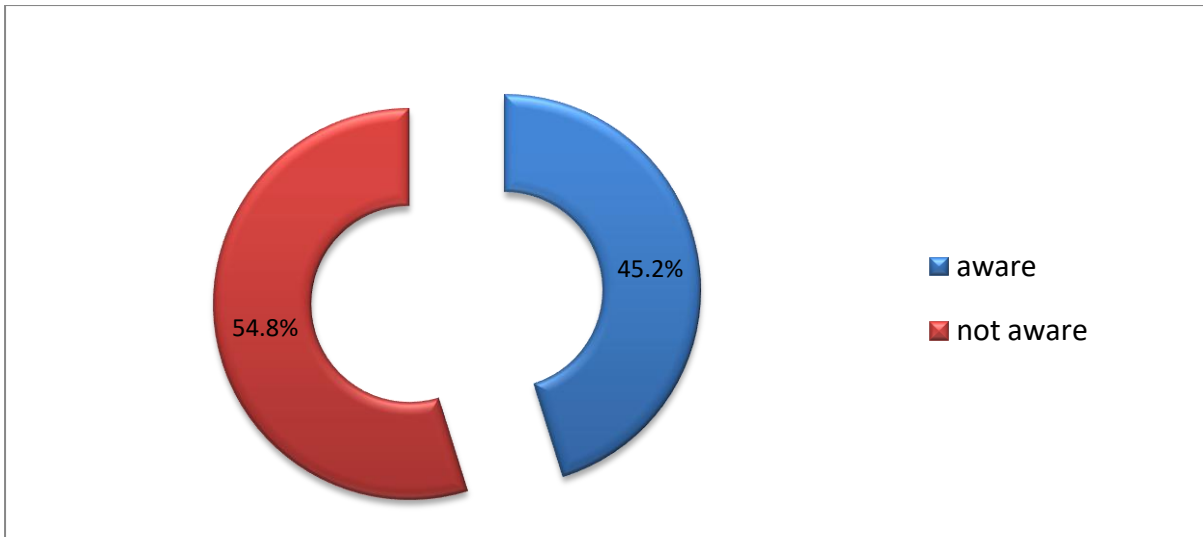
The next text highlighted views from respondents concerning their level of awareness of complications during childbirth. The study expected that when pregnant women were aware of likely complications during childbirth they would choose to deliver in a health facility.

Out of 135 ANC-attendees, 66 percent were aware of some complications that could occur to a pregnant woman during childbirth. However 34 percent out of 135 ANC-attendees were not aware of any complications that could occur to a pregnant woman during childbirth. Figure 4.9 below illustrates these levels of awareness.



**Figure 4.9:** Awareness of Complications during Childbirth: ANC-Attendees

Similarly, the study wanted to establish if the respondents knew any complications that could occur to a baby during childbirth. Consequently, out of 135 ANC-attendees, 45.2 percent knew some of the problems that could occur to a baby during birth. Nevertheless, 54.8 percent of the respondents did not know any complications that could occur to a baby during childbirth as illustrated in Figure 4.10 on page 74.



**Figure 4.10:** Awareness of Complications to a Baby during Childbirth: ANC-Attendees

Concerning the 30 non-ANC-Attendees, 67 percent of them were aware of complications that could occur to a pregnant woman during childbirth. Nonetheless, 33 percent of them were not aware of any complications that could occur to a pregnant woman during childbirth.

On the other hand, 53 percent of them did not know any complications associated with the baby during childbirth while 47 percent knew some complications that a baby could suffer during childbirth. These details are indicated in Table 4.3 below.

**Table 4.3** Awareness of Complications during Childbirth: Non-ANC-Attendees

<b>Variables</b>	<b>%age</b>	<b>No.</b>
Aware of woman’s complications during childbirth	67	20
Not aware of woman’s complications during childbirth	33	10
<b>Total</b>	<b>100</b>	<b>30</b>
Aware of baby’s complications during childbirth	47	14
Not aware of baby’s complications during childbirth	53	16
<b>Total</b>	<b>100</b>	<b>30</b>

From the results in Table 4.3 above, it can be interpreted that, when consequences of complications during childbirth are not envisaged by a pregnant woman due to lack of knowledge of awareness of the same, the possibility of giving birth at home is high.

#### **4.5 Awareness of Advantages of Delivering in a Health Facility**

Level of knowledge of awareness regarding delivering in a health facility was expected by the study to be a precursor to delivering in a health facility. Therefore respondents were asked if they were aware of these advantages. Among 135 ANC-attendees, 60.7 percent of them were aware of some advantages of delivering in a health facility while 39.3 percent of the respondents did not mention any advantage of delivering in a health facility. Some advantages mentioned regarding health facility delivery included management of; excessive bleeding, difficulty labour and avoidance of HIV transmission. For the 30 non-ANC-attendees, 67 percent were not aware any of advantages of delivering in a health. However, 33 percent were aware of some advantages associated with health facility delivery. Thirty percent of the respondents said that sometimes after delivery, the baby could fail to cry and would need experts to deal with the problem.

#### **4.6 Planned Place of Delivery**

Out of the 135 ANC-attendees, 75.6 percent had already specified a health facility where they would deliver their babies, while 17.8 percent had decided that they would deliver in a health facility but did not have a specific facility. A further 2.3 percent had made up their minds that they would deliver at home. On the other hand, 1.5 percent said their husbands would decide where the babies would be delivered.



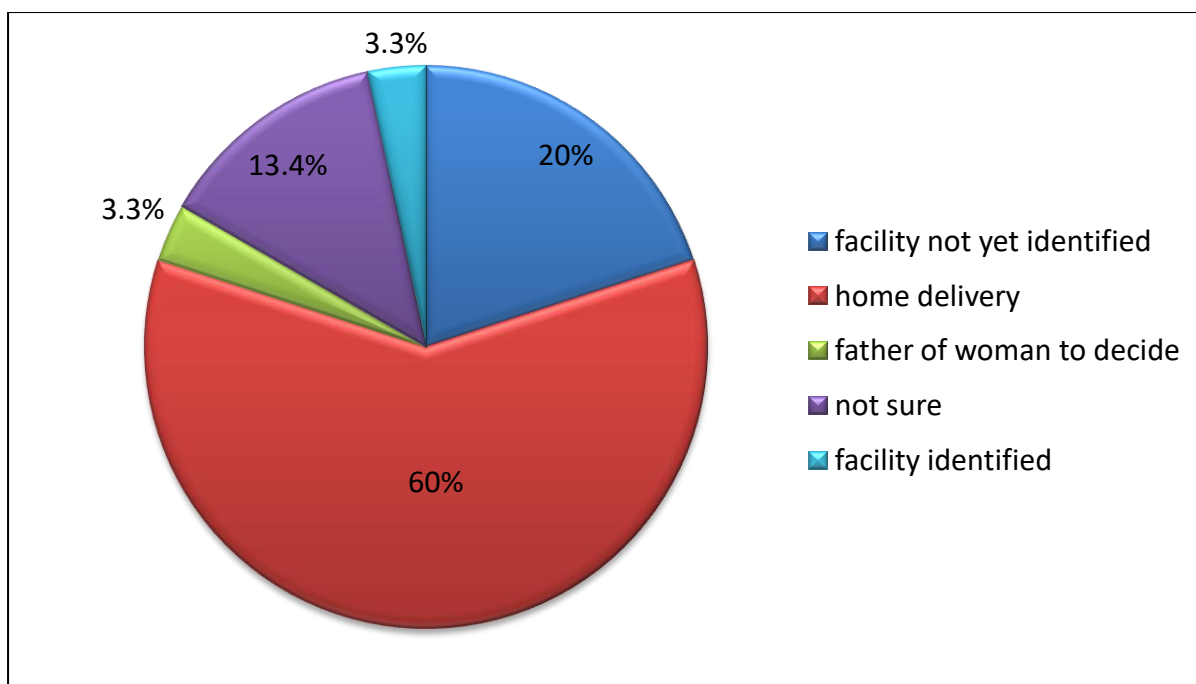
The remaining 4 respondents who added up to 2.8 percent gave various reasons regarding choice of place of delivery as follows; a father of one of the respondents would decide, a mother of one of the respondents would decide, the nurse would choose for the respondent where to deliver and one of the respondents was not sure if to give birth at home or in a health facility. Table 4.4 below illustrates details on planned places of delivery for the ANC-attendees.

**Table 4.4:** Planned Place of Delivery: ANC-Attendees

Facility identified	Facility not identified	Home delivery	Husband to decide	Father of unmarried respondent to decide	Mother of unmarried respondent to decide	Nurse to decide	Not sure where to deliver
102(75.6%)	24(17.8%)	3(2.3%)	2(1.5%)	1(0.7%)	1(0.7%)	1(0.7%)	1(0.7%)

From the information in Table 4.4 above, it is intriguing to note that 4.4 percent had not decided where to deliver their babies despite the fact that they were in the third trimester of pregnancy. It was expected that at this last Phase of pregnancy a woman should have decided where to deliver the baby. It was also surprising to note that 2.3 percent of respondents, despite attendance of ANC, planned to deliver at home.

Among the 30 non-ANC-Attendees, 60 percent had decided they would deliver their babies at home. Twenty percent had an idea that they would deliver in a health facility which was not identified. Some of the respondents (13.4 percent) were not sure about where to deliver their babies. Only 3.3 percent of the respondents had chosen to deliver their baby in a health facility. Nevertheless, another 3.3 percent of the respondents were waiting for the father to decide where to deliver. Figure 4.11 on page 77 highlights these details.



**Figure 4.11:** Planned Place of Delivery for Non-ANC-Attendees

Figure 4.11 above shows that most of the respondents chose to deliver at home. Apparently they did not attend ANC hence they did not get ANC card which is usually a requirement to access health facility delivery services. In this case therefore, majority of the women planned to give birth at home because they did not have other options.

#### 4.6.1 Seeking Permission before Choice of Place of Delivery

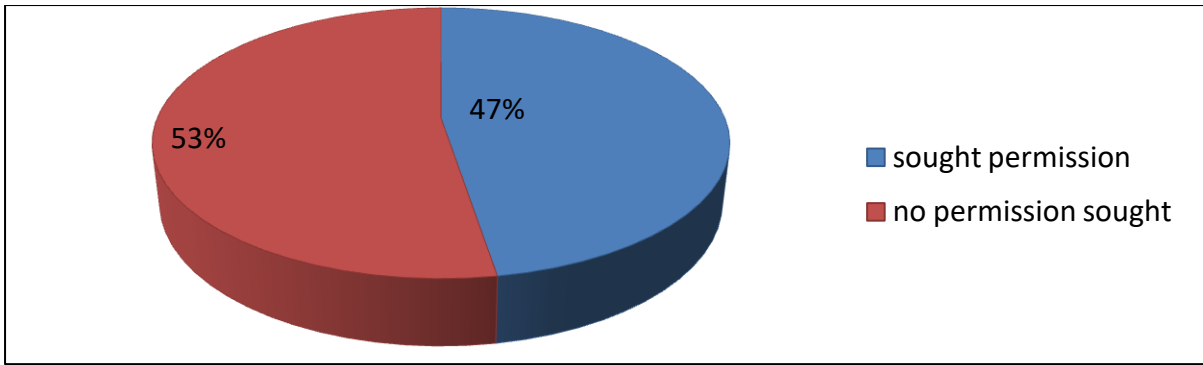
The sharing of the respondents regarding where they delivered their previous children and where they planned to deliver their babies, gave the researcher an indication where the respondents were likely to deliver their babies. Besides, it was important to explore if their choice of planned place of delivery was influenced by others. The study revealed that 47 percent out of the 135 ANC-attendees, sought permission while 53 percent did not seek permission before deciding where to give birth. Table 4.5 on page 78 indicates who gave permission to ANC-attendees and non-attendees before choosing their place of delivery.

**Table 4.5:** Who Gave Permission Where to Deliver

ANC-Attendees			Non-ANC-Attendees		
Who gave permission	%age	No.	Who gave permission	%age	No
-Husbands	50	32	-Mothers-in-law	44.5	4
-Mothers of pregnant women	17.2	11	-Husbands	33.3	3
-Mothers-in-law	17.2	11	-Father of unmarried respondent	11.1	1
-Fathers of unmarried respondents	4.6	3	-Grandmother	11.1	1
-Fiancés	3.1	2			
-Grandmother	3.1	2			
-TBA	1.6	1			
-Parents	1.6	1			
-Family members	1.6	1			
<b>Total</b>	<b>100</b>	<b>64</b>		<b>100</b>	<b>9</b>

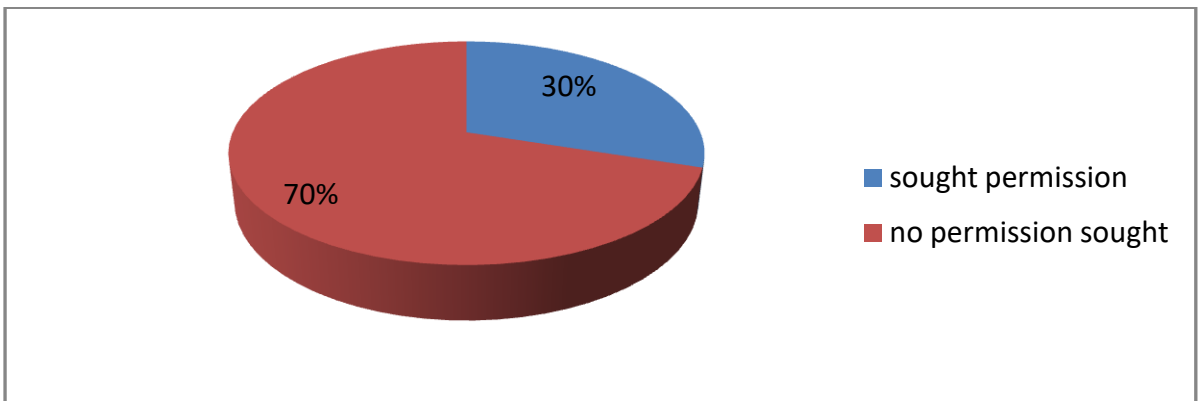
From the results depicted in Table 4.5 above, it was evident that out of the significant others who gave permission regarding place of delivery, husbands played a significant role followed by mothers-in-law and mothers of some of the unmarried respondents for the women who were ANC-attendees. For the non-ANC-Attendees, the reverse was true that the mother-in-law was the main character followed by the husband. Figure 4.12 on page 79 illustrates percentages of pregnant women who sought or did not seek permission before deciding place of delivery for 135 ANC-attendees.

Figure 4.12 on page 79 revealed that 53 percent of the ANC-attendees had the autonomy over where to deliver their babies. Nonetheless, those who lacked the autonomy in choosing the place of delivery in this category were still high at 47 percent. It is common sense to deduce that when choices are made on behalf of a pregnant woman, sometimes the decisions might be unfavorable for both mother and baby. Sometimes, some husbands, a mother-in-law or the mother of the pregnant woman may insist that she should deliver at home when the case needed an urgent medical attention.



**Figure 4.12:** No. that Sought Permission Regarding Where to Deliver: ANC-Attendees

Out of 30 non-ANC-attendees, 70 percent did not need to seek permission from anyone before deciding where they would deliver their babies. However, 30 percent of the respondents sought permission from significant others before deciding where to deliver their babies. Figure 4.13, below shows who sought or did not seek permission regarding where to deliver the baby.



**Figure 4.13:** Sought Permission Regarding Where to Deliver: Non-ANC-Attendees

**4.7 Summary**

Common aspects noted from the study findings in this section included the influence of age in determining preferred place of giving birth. Previous childbirth experiences whereby, if prior deliveries were safe the woman was likely to give birth at home and the converse was true that if she faced complications, she would deliver in a health facility. The outcome of

this study findings indicated that, transport and road networks were insignificant in determining where a pregnant woman delivered. It is observable that a significant number (93.3 percent) of ANC-attendees planned to deliver their babies in a health facility in case of childbirth complications and encouragement by significant others. On the contrary, 60 percent of non-ANC-Attendees planned to deliver at home influenced by previous safe deliveries and encouragement by significant others.

## **5.0 CHAPTER FIVE: THE ACTUAL PLACE OF DELIVERY AND REASONS**

### **5.1 Introduction**

Chapter five covers Phase II of the study which established where ANC-attendees and non-attendees finally delivered their babies and what influenced their choice. This was objective 2 of the study which sought to determine where both ANC-attendees and non-attendees finally delivered and the reasons. It was the plan of the study to follow the expectant women interviewed in Phase I within 2 weeks after delivery to determine whether the actual place of delivery was in agreement with the information they had given during their third trimester (7-9 months) of pregnancy. The span of the whole exercise took 4 months.

### **5.2 Actual Place of Delivery**

In Phase 1, 75.6 percent out of 135 ANC-attendees had specified the specific facilities they intended to deliver and 17.8 percent had given the intentions to deliver in a health facility but had not yet specified the facility. Among the 30 non-ANC-Attendees, only one (3 percent) respondent in this group had identified a health facility as place of delivery while 6(20 percent) of them had previously expressed intentions to deliver in health facilities though they had not identified them. Interesting things happened when the time to deliver the babies arrived. First, focusing on the 135 ANC-attendees, a number of things are observable. Surprisingly and contrary to the expectation of the study, only 64 percent out of 135 ANC-attendees indicated that they actually delivered in a health facility while the remaining 36 percent delivered at home. Regarding the 30 non-ANC-attendees, only 10 percent actually delivered in health facilities according to the results and overwhelming majority, 90 percent delivered at home contrary to their earlier indication of 60 percent who had planned to deliver at home.

The concern observed was the big gap between those who had expressed their intention (93.4 percent) to deliver in a health facility and the actual percentage of 64 who actually did so among the 135 ANC-attendees. On the other hand, among the 30 non-ANC-attendees, an increase of 30 percent of those who delivered at home was observed.

### **5.2.1 Reasons that Determined Where to Deliver**

This study revealed that identification of the place where to give birth among the pregnant women was determined by; awareness of complications that could occur during childbirth, confidence in the TBA, precipitated labour, actual previous complications during childbirth, freedom of choice of place of delivery by the pregnant woman, fear by TBAs of contracting HIV and influence of significant others and previous safe deliveries. The next discussion therefore covers the determinants of choice of place of delivery as identified by the respondents. The results are based on the 64 percent out of 135 ANC-attendees who delivered their babies in a health facility, 36 percent out of 135 who were ANC-attendees but delivered their babies at home, 10 percent out 30 non-ANC-Attendees who delivered their babies in a health facility and 90 percent out of 30 ANC-attendees who delivered their babies at home.

### **5.2.2 Previous Complications during Childbirth**

Out of 135 ANC-attendees, 86(63.7 percent) of them delivered in a health facility and 49(36.3 percent) at home. Thirteen (15 percent) respondents out of 86 ANC-attendees delivered their babies in various planned health facilities because of the prior complications they suffered during childbirth. According to these respondents, they did not want to risk by delivering their babies at home. For instance, Kavutha, Kalunda, Kanyiva, Nzisa, Katunge, Muke and Mutindi had previously delivered their children through caesarean section and they were informed by the nurses never to try to give birth at home because the caesarean scar

could rupture. The above referred seven respondents delivered 4 girls and 3 boys once again through caesarean section. Other 2 respondents out of the remaining 6, Kathini and Mbaki gave birth in a health facility because of a different experience altogether. According to these 2 respondents, they had previously lost their first born babies and they did not want to take a chance by delivering at home. These 2 respondents delivered baby girls safely in various health facilities. On the same note, Mwia and Kathathi out of the remaining 4 respondents maintained that they gave birth in a health facility since their previous children were born before term (premature). For that matter, giving birth in a health facility was their desired option because of the professional care given according to them. These 2 respondents delivered safely baby girls. The remaining 2 respondents, Silingi, and Kavata delivered their babies in a health facility because of different challenges. For instance, Silingi had previously experienced prolonged labour as a result of irregular labour pains at home while Kavata vomited after giving birth to her previous child. These 2 respondents pointed out that they gave birth in a health facility because they were afraid that the same experiences could reoccur. This time around the respondents gave birth to 2 girls without undue suffering.

### **5.2.3 Complications in the Process of Childbirth**

Problems during childbirth at home necessitated both ANC-attendees and non-attendees to be referred by TBAs to various health facilities for further management. Out of the 86 ANC-attendees, 20 percent of respondents delivered their babies in a health facility because they experienced problems in the process of childbirth. Sixty five percent out of the 17 respondents experienced prolonged labour at home and the TBAs assisting in these deliveries had no other option but to refer the respondents to health facilities for professional help. For instance; Ndinda, had prolonged labour and the TBA tried to assist her without avail. As a result of this problem, she was accompanied by her sister who was a TBA and her mother to Kitui County hospital where she delivered a baby boy through cesarean section.



She did not suffer from any complications after delivery. Nduma suffered prolonged labour as well and the TBA suggested to the family members that she should be transferred to Kauwi health facility. The family members assented and Nduma was taken to the health facility where she delivered a baby girl which was put on oxygen because she developed difficulties in breathing. The baby's condition gradually improved.

Nduume had primarily planned to give birth in a health facility but later changed and decided to give birth at home. During the process of labour, she was transferred by the TBA to Kalimani health facility because of prolonged labour where she gave birth to a baby girl without any problem. Munini had similar experience like the rest of the above respondents. She initially had planned to deliver in a health facility but later decided she would deliver her baby at home. In the process of labour, the TBA realized that the delivery was taking too long than it was anticipated. She was transferred to Kitui County hospital where she delivered a baby boy without any problem. Though Koki and Mwongeli had intended to deliver their babies in a health facility which they had not specified, when labour pains set in, they decided to give birth at home. These 2 respondents affirmed that the decision to give birth at home was based on the fact that they could not foresee any problem during childbirth as they had always delivered their babies without any childbirth complications. For instance, Koki was 31 years old and had given birth to 3 children safely in a health facility while Mwongeli who was 28 years old, had 3 safe deliveries at home. However, both of them developed prolonged labour and were transferred by the TBAs to a health facility. One of them was transferred to Muthale Mission hospital where she was put on drip and eventually delivered a baby boy. The other one was transferred to Iiani health facility and she gave birth to a baby girl. Muna experienced irregular labour pains while being assisted at home by a TBA. Labour failed to progress and according to the TBA assisting in the delivery, cervical dilation seemed not to progress either. Muna was eventually taken to Kitui County hospital but she lost her baby boy

because she arrived in the hospital too late. Other 4 respondents, Kula, Kwita, Kumela and Kanyoi suffered similar prolonged labour ordeal as their above colleagues trying to deliver at home under the patronage of TBAs. These respondents were consequently transferred to different health facilities by the TBAs. Ndunge conceded that she was delivering at home and unfortunately the baby presented itself with the legs instead of the head which posed a problem to the TBA. She was rushed to Muthale mission hospital where she delivered a baby girl which was a stillbirth. Mbaika, narrating a similar experience during childbirth had the following to say:

*My mother-in-law who was assisting me during delivery was taken aback when she realized that after delivering the 1<sup>st</sup> baby (a girl), there was yet another in the womb which could not be delivered normally. There was delay to get to the health facility because there was no money for transport. By the time we reached Kauwi health facility, it was too late to save my baby's life. To my disappointment, the baby (a boy) was delivered but lifeless, [in-depth interview].*

Nziva, who was 34 years old, had 3 children of which one was delivered at home. In all her deliveries, she never experienced any problem during childbirth. She pointed out that her mother-in-law played a key role in influencing her choice where she delivered her baby because the former was more experienced in childbirth. Nevertheless she ended up in a health facility. After giving birth to a baby girl, she started bleeding excessively and the TBA gave her some cold milk and some herbs but the bleeding did not stop. She was taken to Matinyani health facility where some membranes were removed from the uterus and she was given some injections and the bleeding stopped within a short while.

From the above verbatim, it is observable that pregnancies can be different. The fact that 3 previous births were safe at home does not mean the 4<sup>th</sup> will be safe too. It is also observable that errors of failing to determine the number of babies in the uterus during pregnancy, increases the risk of delivering at home. Mukai's case was different from the

above cases because, according to her she had intended to deliver her baby at home but the TBA advised her otherwise. Her narration was as follows:

*I wanted to give birth at home. However I was advised by the TBA to seek medical help because my pelvis structure was too small to allow for normal delivery. I insisted that I wanted to deliver at home since I believed all would be fine. Before the onset of labour, I experienced bleeding and I remembered one of the lessons taught during ANC was to be particularly attentive to bleeding from the genital tract because this could amount to childbirth complications. I was taken to Kitui County hospital where I delivered a baby boy through caesarean section, [in-depth interview].*

Kavuvu was 26 years old and had 2 prior deliveries in a health facility without any complications. At first she had planned to give birth in a health facility but changed when labour pains set in and called a TBA to assist. According to Kavuvu, she had enough experience in childbirth and she did not see the need of giving birth in a health facility. However her experience of childbirth was different this time as narrated in the following extract:

*When I started experiencing labour pains, my mother-in-law and a TBA stayed with me. Progression of labour was promising in the beginning but slowly labour pains subsided and yet the 'waters had broken' (amniotic fluid had poured). The TBA and my mother-in-law informed my husband that I should be transferred immediately to Kitui County hospital for further management. In Kitui hospital I was put on drip and within 2 hours I delivered a baby girl [in-depth interview].*

Makusa's childbirth experience was not different from Kavuvu's. According to Makusa, she had wished to deliver in a health facility but later changed and opted to deliver at home as she did not expect any problems during childbirth. When labour pains began she called a TBA. However, things did not work out as it was anticipated as recounted in her following experience. *"In the process of labour, we realized that there was poor progression of labour pains. They were irregular and weak to push the baby in order to quicken the delivery process. The TBA and a relative accompanied me to Maseki health facility where I delivered a baby boy without problems"*.

As already observed, 10 percent out of 30 non-ANC-attendees delivered in a health facility not because of their own volition. According to Mutuli aged 30, Kaluki aged 32 and Kasau aged 19, their plan was to give birth at home which was not possible because they experienced complications in the process of childbirth at home. Each respondent shared their experiences as under:

Mutuli's experience during childbirth was captured in the extract below:

*Though I had decided to give birth in a health facility, I changed my mind and chose to give birth at home as usual. Bearing in mind that I had delivered all my 4 children at home without any childbirth complications, I did not expect to have any problem in the process of giving birth. Even so, things were different this time. In the course of labour we realized that the baby was not being born as anticipated and the TBA decided that I should be taken to Matinyani health facility. On the way to the health facility, I could not feel the baby's movements and I got worried. On arrival at the health facility, the nurse examined me and said she could not hear the fetal heart. I was shocked to hear this. I was put on drip and after sometime I delivered a baby boy who was dead. I was devastated because I was longing to have a baby boy, [in-depth interview].*

According to Kaluki, at the time of giving birth, the TBA realized that she was too weak to push the baby out of the womb. Her husband called a pastor to pray for her because he believed that she was bewitched. The pastor prayed but without avail. The TBA called for the nurse from Kalimani health facility to prevail over the husband to take his wife to a health facility. Kaluki was taken to Kalimani health facility but her blood pressure was high and her body was swollen too. The nurses at Kalimani could not manage the condition, so she was transferred to Kitui County hospital where she eventually delivered safely a baby girl. The last respondent in this group, Kasau narrated her experiences as follows:

*I had planned to deliver my baby at home assisted by a TBA. However when I started experiencing labour pains, my mother-in-law called a TBA to conduct the delivery. For a full day and until evening there was no sign that I was going to deliver soon. The pain was intense and I was exhausted. My mother-in-law and the TBA accompanied me to Muthale mission hospital where I had a normal delivery. The nurse said I was lucky the baby was alive because the cord of the baby had coiled around the neck which was strangling the baby as it tried to advance for birth, [in-depth interview].*

#### **5.2.4 Influence by Significant Others**

The role played in choosing place of delivery for respondents by; mothers-in-law, husbands, fathers, mothers and grandmothers of the unmarried pregnant women who are referred to as significant others in this study was important. Significant others either influenced respondents to deliver their babies at home or in a health facility. For instance, out of 64 percent among 135 ANC-attendees who delivered in a health facility, 34 percent were encouraged by their significant others to deliver in a health facility.

Out of the above 34 percent of respondents referred, 56 percent of them were encouraged by husbands, 21 percent of them who were unmarried by their mothers, 7 percent by their mothers-in-law, 7 percent of unmarried respondents by their fathers, 3 percent by fiancé, 3 percent by family members and 3 percent by parents of one of the respondents. On the other hand, 2 percent of the respondents delivered in a health facility because TBAs refused to conduct deliveries because of HIV transmission. On the other hand, out of 49 ANC-attendees who delivered at home, 36.7 percent delivered at home having been influenced by significant others. Thirty three percent of these significant others included mothers-in-law, husbands 27 percent and 22 percent were mothers of unmarried respondents. One (6 percent) unmarried respondent was encouraged by her father to deliver in a health facility. Another one (6 percent) respondent was encouraged by her fiancé while the last respondent (6 percent) was encouraged by her grandmother to deliver in a health facility also. To back up the substantial role played by mothers-in-law in influencing choice of place of delivery, 6 respondents out of 18 claimed that their mothers-in-law decided for them where they should deliver their babies claiming that they knew what was best for their daughters in law regarding childbirth. Nonetheless, some of the respondents suffered in the process of giving birth at home.

For instance, Ndungwa, sharing her experience during delivery at home contended that, she was encouraged by her mother-in-law to give birth at home because she had previously delivered 3 children safely at home. However during delivery, she suffered from excessive bleeding which made her dizzy and she lost consciousness. She was rushed to Neema health facility where she was transfused blood.

On a similar account concerning the role played by mothers-in-law, Kavusi pointed out that her mother-in-law planned for her to give birth in a health facility but she had not identified a particular one. It was until labour pains began that her mother-in-law realized it was too late to make arrangements to go to a health facility. Her mother-in-law called a TBA to conduct the delivery and Kavusi gave birth safely. Mbaluta, who was 34 years old, had previously delivered one child at home. She was avidly encouraged by her mother-in-law to give birth at home since she had not experienced any complications in her previous deliveries. Unfortunately after delivery, the baby did not cry immediately after birth. The TBA and the mother-in-law ‘banged tins’ hoping the noise would make the baby to cry. This method did not work. The last option was to splash cold water on the baby which worked. Nasi was also urged by her mother-in-law to give birth at home. Even though she was reluctant at the beginning, she finally acceded to her mother’s in law views for the sake of peace. The remaining 2 respondents conceded that their mothers-in-law encouraged them to give birth at home which they did. Place of delivery for 5 respondents was chosen by their husbands. For instance, Kathina said that she was surprised when her husband insisted that she had to give birth at home. To expound on her experience she further said, *“Although I had planned to deliver my baby in a health facility, when my husband discovered that I was in labour, he called a TBA instead of organizing for transport to a health facility. Nevertheless the TBA conducted the delivery safely at home”*. Other 2 respondents out of 5 did not know why their husbands chose for them to give birth at home. Their husbands

simply dictated where the delivery would take place. Surprisingly, one respondent among these 2 did not take offence when her husband chose place of delivery for her. Sharing her experience along the same line of choice of place of delivery she said, *“I delivered safely at home because I was encouraged by my husband to deliver there. In fact I had intended to give birth in a health facility though I had not specified a particular one”*. Two other respondents maintained that their husbands were the custodians of the family assets and had the mandate to decide where the baby would be delivered. On the same note, they further claimed that since their husbands were the heads of the family according to Akamba culture, they had absolute right to identify place of birth for the baby, *[in-depth interview]*

This study also revealed that 8 percent of mothers of unmarried respondents out of 49 played a role in determining on behalf of their daughters where the baby should be delivered. For instance, Mwende’s mother had promised to support her to give birth in a health facility which was not identified. Mwende ended up delivering her baby girl at home assisted by a TBA since her mother did not identify the health facility where she could deliver. Likewise other 3 respondents were encouraged by their mothers to give birth at home assisted by TBAs since the position of the baby in the uterus was okay and normal delivery was envisaged. According to Mbaunzi’s mother, by delivering the baby at home, expenses of giving birth in a health facility such as hiring a vehicle was avoided. Keli and Kasungu accepted the wish of their mothers to give birth at home. These young pregnant women had to comply because they were under the custody of their mothers since they were not married.

A father of one of the unmarried respondent, a grandmother and a fiancée played a significant role in determining where the babies would be born of the 3 respondents as revealed in this study. For instance, Wandia’s father encouraged her to deliver her baby at home. *“My father encouraged me to deliver at home because of the care and concern by relatives. When labour pains began, a TBA was called and I delivered a baby boy safely at*

home”, said Wandia. Mulau was persuaded by her grandmother to give birth at home since she was living with her. She contended that her grandmother assured her of safe delivery because the baby’s head in the uterus was presenting and normal delivery was possible. *“I did not see then the need of delivering in a health facility since my grandmother was a good TBA”*, said Mulau. However, Mbuva had a different experience during childbirth at home. Her experience was captured in the extract below:

*My fiancée had promised to support me to give birth in a health facility but he was not available at the time when labour began. I was so disappointment because my family members were not prepared pecuniary wise for a delivery in a health facility. I did not have money to facilitate my movement from home to the health facility. The only option was to call a TBA who conducted the delivery. I delivered a baby boy without any challenge, [in-depth interview].*

For the 30 non-ANC-attendees, 37 percent out of 27 respondents who delivered at home were encouraged by significant others who included husbands, a father and a mother of some of the unmarried respondents, a mother-in-law and a grandmother. For instance, Mukeli aged 19, and expecting her first baby, delivered a baby boy at home because of her father’s influence. Mukii aged 22, whose grandmother was a TBA and being the one responsible for choosing where the respondent would deliver, the latter conducted the delivery and Mukii delivered a baby girl safely. Wambu aged 34, gave birth to a baby boy at home encouraged by her mother. The mother told her, *“You have delivered your previous 4 children at home safely; this one will be fine too”*. Syomiti said, *“My mother-in-law and my husband encouraged me to give birth at home and I complied because I did not want to cause a conflict in the family. The delivery was conducted by a TBA where I delivered a baby girl”*. The place of delivering the baby for the rest of the 6 respondents; Syokwia, Mwiia, Mwiitu, Wakyende, Wendo and Musau was determined by their husbands.



Syokwia had previously delivered 2 children safely, one in a health facility and the other at home. Mwiia and Mwiitu had previously delivered 4 children each at home without any childbirth complications. *“My husband told me to deliver the current baby at home. When he noticed that I was in labour he called a TBA and I delivered a baby girl”*, said Mwiia. Just as Mwiia, Mwiitu delivered at home assisted by a TBA and her mother-in-law as planned by her husband. Wakyende, Wendo and Musau all delivered at home assisted by TBAs as proposed by their husbands. These 4 respondents delivered 3 girls and one boy respectively. Wakyende, Wendo and Musau safely delivered 3 of their children at home. They maintained that, their husbands were the head of their families and therefore they were responsible for determining where the baby would be delivered.

#### **5.2.5 Awareness of Complications during Childbirth**

Awareness of possible complications during childbirth influenced respondents to give birth in a health facility. Six percent of the 86 ANC-attendees, who delivered in a health facility, did so because they were aware of complications that could occur in the process of childbirth as confirmed by one of the respondents. *“Being my first pregnancy, I was careful to give birth in a health facility because complications associated with childbirth could also occur to me”*, she said. This respondent gave birth to a baby boy in a health facility as planned. Other respondents in this group cited the following conditions which could occur during childbirth; excessive bleeding and retained membranes after giving birth, a baby swallowing amniotic fluid during birth and developing difficulties in breathing after birth leading to the death of the baby. Kaveke and Nzilili were articulate about these childbirth complications. For instance, Kaveke pointed out: *“Being my first pregnancy, it was crucial to deliver in a health facility because complications associated with childbirth such as the baby developing difficulties in breathing could also occur to my baby”*. She delivered a baby boy safely in Kitui County hospital. Nzilili on the other hand pointed out that it was frightening to

bleed excessively after delivery and so she preferred to give birth in a health facility. The rest of the 2 respondents in this group of those who were aware of childbirth complications gave birth to a boy and a girl in respective health facilities.

### **5.2.6 Previous Safe Deliveries**

A previous safe delivery was a precursor to home deliveries for ANC-attendees and non-ANC-Attendees. Out of 49 ANC-attendees, 24.5 percent delivered at home despite attending ANC. These respondents bragged that they had continued giving birth at home because of their previous safe deliveries. These deliveries were attributed to the number of children one had delivered and an assumption that all deliveries were the same. For instance, Maua (38 years old) Mang'ele (36 years old), Kavithe (35 years old), Ndeveimwe (34 years old) opted to give birth at home on account of their safe previous deliveries and experience in childbirth. Ndeveimwe had previous safe deliveries of 3 children in a health facility and she believed that delivery could safely be conducted at home. Therefore during labour her mother-in-law invited a TBA who conducted the delivery successfully. On the same note, Nthenya (35 years old), Nzila (35 years old), Syombua (34 years old), Syokau (32 years old) and Kaluu (30 years old) decided to deliver at home since they had previously given birth to children at home without complications.

Although Wanza (29 years old), Kaluma (27 years old) and Mukethe (25 years old) wanted to give birth in a health facility, each one of them had planned to give birth at home since they did not envisage any complications during childbirth at home as they were used to delivering at home without undue suffering. In conclusion, these respondents gave birth at home without complications.

Focusing on the 30 non-ANC-attendees, 90 percent of them delivered their babies at home. Out of this number, 37 percent delivered at home because of previous safe deliveries.

For instance Mukui aged 36, narrating her experience said:

*I did not see the need of delivering my baby in a health facility after delivering 4 children at home assisted by a TBA without problems. I felt comfortable giving birth at home where the environment was familiar. Having delivered those 4 children at home safely, it was a clear sign that subsequent deliveries would be safe too. Therefore, that is why I delivered my baby girl at home because I did not see the need of delivering in a health facility, [in-depth interview].*

The remaining 9 respondents just like Mukui delivered their babies at home because of similar experiences of previous safe deliveries. For instance, Ngundo (32 years old) delivered her 4 children at home safely; Mwikya (23 years old) had delivered one of her 2 children at home successfully, Mengo ( 21 years) delivered her first child at home assisted by a TBA safely, Mwongeli ( 24 years) had delivered her 2 children also at home and never experienced any problems at all. She said that there was no need of delivering her baby in a health facility since she had not faced any problems.

Mwini (30 years old) said, *“I chose to give birth at home because I did not see delivery as a big deal having delivered at home twice without any problem”*. Another respondent in this group, Ndungu aged 32 said, *“I have delivered 3 children, one in a health facility and the other 2 at home without any childbirth problems. Therefore I delivered a baby boy at home because I did not foresee any childbirth problems”*. The other remaining 3 respondents; Mukina aged 30, Mwove aged 26 and Kasumini aged 24 each gave their reasons for delivering their babies at home as follows. Mukina said, *“I delivered at home to avoid logistics of transport. Actually I delivered my first born at home and there was no problem”*, while Mwove said; *“I avoided giving birth in a health facility because a woman was expected by the nurse to buy new clothes for the baby which I find expensive. That is why I delivered at home”*.

This respondent concluded by pointing out that since she never experienced any problem during her first delivery at home, there was no need of bothering to deliver her baby in a health facility. Kasumuni on her part said, *“I delivered at home because I felt encouraged when I saw my relatives around me. Furthermore, the TBA was always kind and massaged my abdomen and the back to relief pain. When I delivered my first born safely in a health facility, I decided all other deliveries would take place at home assisted by a TBA”*. The above 8 respondents gave birth to 5 girls and 3 boys at home.

### **5.2.7 Confidence in the TBA: ANC-Attendees and Non-Attendees**

Some of the ANC-attendees and non-attendees delivered at home because of the confidence they had in TBAs. Out of 49 ANC-attendees, 14.3 percent delivered at home because of the confidence they had in TBAs after being assured by the latter that normal delivery was possible. Although, Mwikali had previously lost a baby during delivery at home, surprisingly, she still gave birth at home assisted by a TBA without any recourse to her previous loss under the patronage of a TBA. Nonetheless according to Mwikali, the death of her previous baby was God’s design and it had nothing to do with the place of birth or the TBA conducting the delivery. However this time she delivered a baby girl without any problem. Nthoki seemed to have had real faith in TBAs, because she had been advised by the nurse to give birth in a health facility. Surprisingly she decided to give birth at home when the TBA assured her of a safe delivery at home. Against all odds, she delivered a baby boy safely. Ndini was contemplating delivering her baby in a health facility until labour pains began. In her narration she said, *“To avoid logistics of going to a health facility, when labour pains began I requested my husband to call a neighbour who was a good TBA. I was convinced that I was going to deliver normally without a problem since I never experienced any problems during my last delivery. As anticipated I delivered a baby girl without problems”*.

Velesi on her part also narrated her experience during childbirth, she said:

*The membranes ruptured early and the amniotic fluid drained out and I started bleeding, but I was confident all would be well. The TBA and my mother-in-law massaged my abdomen with coconut oil and administered some herbs to induce labour pains. After sometime I experienced strong contractions and gave birth to a baby boy and the bleeding stopped [in-depth interview].*

Even so, 2 respondents among those who were assured by the TBAs of safe delivery at home, experienced childbirth problems (excessive bleeding) as they attempted to give birth at home. For instance, Mbeneka, 36 years old had 2 children, one of which was born at home and the other one in a health facility without problems. According to the respondent, the TBA had assured her of a safe delivery at home. Unfortunately after giving birth she started bleeding excessively because the placenta was retained. The TBA managed to deliver it and after sometime the bleeding eventually stopped. Mbinya suffered from excessive bleeding after delivering a baby girl because of retained placenta too. According to the respondent, the TBA and the mother-in-law put a tip of a rope in her mouth to enforce her to vomit so that the same force could exert pressure to expel the placenta. This happened and the placenta was expelled and the bleeding stopped. The remaining one respondent said, *“I delivered my 2 children safely at home assisted by a TBA and therefore I did not anticipate any complications delivering at home”*. She delivered a baby boy.

Twenty six percent of the respondents out of 30 non-ANC-attendeess delivered their babies at home because of the confidence they had in the TBA. Mumo aged 38, described her experience during childbirth in the following text:

*I delivered all my 8 children at home successfully with encouragement from my husband. He always brought a TBA to conduct the deliveries. But I really wanted to deliver this baby in a health facility as I was informed by the nurse because of my age. But I did not see the reason of giving birth in a health facility since the TBA had assured me that the position of the baby in the uterus was okay and progression of labour was fine. I began bleeding excessively immediately after birth.*

*I was given a mixture of 'omo' (powder soap) and water and some concoction to drink in order to stop the bleeding which worked. But I felt dizzy and weak after this. I was accompanied by my mother-in-law and my husband to Kitui County hospital where I was transfused blood because I was anaemic. I delivered a baby boy [in-depth interview].*

Mukulu aged 32, and one among the 7 respondents who had full confidence in the TBA, had delivered 6 of her 8 children at home without complications. Her 2 previous children delivered in a health facility was as a result of prolonged labour at home and the respondent was transferred to a health facility by the TBA. This respondent maintained that she was assured by the TBA that safe delivery was possible since the position of the baby in the uterus was okay. The respondent successfully delivered a baby boy. Kakulu aged 38, also had delivered all her 7 children at home without any childbirth problems. In spite of the fact that she had been cautioned by the nurse to give birth in a health facility, she finally delivered a baby girl at home after the TBA made the assurance that progression of labour was fine. Kutu aged 35 years had delivered her 4 children at home without complications with assurance from the TBA. This respondent delivered a baby boy at home after being assured by the TBA that safe delivery was possible. Mutunge, unmarried, and aged 28, was expecting her first baby. Although she had attained secondary level of education, her mother convinced her to delivery at home under the care of the renowned village TBA who was her best friend. This respondent complied with her mother's plea and gave birth to a baby boy at home. The other remaining 2 respondents gave birth safely at home after the assurance from the TBA that home delivery was possible. These 2 respondents gave birth to 2 girls.

### **5.2.8 Precipitated Labour and Delivery at Home**

Out of 49 ANC-attendees, 6.1 percent of the respondents delivered their babies at home on account of quick labour (precipitated labour). Malinda had planned to deliver her baby at Kalimani health facility, but this did not happen. She was relaxing alone at home and suddenly childbirth pains started. She quickly informed her neighbor who responded immediately. The pains intensified such that there was no time to arrange to go to Kalimani health facility. The neighbor assisted her and Malinda gave birth to a baby boy. Like Malinda, Malomo planned to deliver in Ndiuni health facility, but due to experience of precipitated labour, she ended up delivering a baby boy at home alone. The remaining respondent said, *“I actually delivered a baby girl at the gate of Kauma health facility because labour period was short and I could not reach the labour ward”*.

### **5.2.9 Pregnant Woman’s Freedom in Choosing Place of Delivery**

Out of 86 ANC-attendees who delivered in a health facility, 23 percent of the respondents chose on their own accord to deliver in a health facility. On the same note, out of 49 ANC-attendees, 18.4 percent chose to deliver at home without any influence. One of the respondents in this group had strong feelings regarding freedom of choice of place of delivery. She said, *“Delivery is delivery, whether at home or in a health facility, it is the woman who delivers and not the nurse”*.

After reading the above narratives, one realizes that there is no need for women to deliver at home because of the undue suffering they go through. They should be encouraged to deliver in a health facility.

### 5.3 Testing of Hypothesis

The findings of this study proved that the study hypothesis which stated that: *The level of pregnant women's knowledge of awareness concerning advantages of giving birth in a health facility assisted by a professional health care provider in Kitui West Sub-county, is positive in relation to the women's choice of place of delivery.* Awareness of advantages of delivering in a health facility was expected by the study to be a precursor to the pregnant women to deliver in a health facility. Out of the 135 ANC-attendees, 60.7 percent and 33 percent of the 30 non-ANC-attendees were aware of some advantages associated with health facility delivery. Interestingly, this knowledge did not influence the respondents' final place of delivery. To prove this claim, 36 percent of 135 ANC-attendees and 90 percent of the 30 non-ANC-attendees delivered at home. This hypothesis was therefore statistically found to have no positive association with preferred place of delivery. This argument was attested by the Chi-square test analysis ( $\chi^2=14.018$ ;  $df= 8$ ;  $p=0.081$  where  $p\leq 0.05$ , cf. appendix 7, p174). This meant that there was no association between knowledge of advantages of delivering in a health facility and place of delivery.

### 5.4 Summary

In comparison with the planned place of delivery and where the respondents finally delivered, there was a glaring difference. For instance 93 percent of ANC-attendees intended to deliver in a health facility but only 64 percent ended up giving birth in a health facility. Interestingly only 2 percent of these respondents had planned to deliver at home but 36 percent ended up giving birth at home positing an increase of 34 percent. On the other hand, out of the 30 non-ANC-attendees, 60 percent had indicated that they would deliver their babies at home. This percentage increased by 30 to stand at 90 percent at the time of delivery.



So far this study work focused on actual place of delivery and the reasons thereof which was objective 2 of the study. It was also necessary to hear the perspectives of other actors who interacted with the women during pregnancy and childbirth. These respondents included TBAs and nurses who formed the discussion of the next chapter.

## 6.0 CHAPTER SIX: OPINIONS OF INFORMANTS ON CHOICE OF PLACE OF DELIVERY

### 6.1 Introduction

This chapter explored the opinions of the informants on choice of place of delivery for pregnant women in Kitui West Sub-county, which was objective 3 of the study. These informants were; 5 nurses and 8 TBAs. The first part of this discussion captured perspectives of TBAs and the second part highlighted responses from the nurses while the last part focused on policy implications on the role of TBAs in childbirth.

### 6.2 Results of the Traditional Birth Attendants

To gather information, the informants answered a set of questions in order to establish their views regarding choice of place of delivery for pregnant women. To explore what would make pregnant women alter plans of delivering in a health facility and deliver at home, the TBAs were asked, **is there a time a pregnant woman plans to deliver in a health facility but later chooses to deliver at home?** This question elicited common views from the 8 TBAs. In response to the question, all the 8 TBAs said that it was likely for a pregnant woman to plan to deliver her baby in a health facility and later deliver at home because of various reasons. For instance Ng'anduna said:

*Yes it happens, sometimes labour can be quick and alter original plans of delivering in a health facility hence making the woman to deliver at home. There are other women who deliver on their way to a health facility. Some pregnant women can decide to deliver at home assisted by a TBA but if the TBA realizes that delivery cannot take place at home due to difficult labour, the pregnant woman is taken to a health facility by her relatives. A case in point was a woman whom I was assisting during childbirth. As I assisted this woman, I realized that labour was not progressive as expected. As a result of this experience, I accompanied her to a health facility where she underwent cesarean section because the baby's cord coiled around the neck, [TBA. Informant].*

Regarding quick labour as mentioned above by Ng'anduna, Ng'amuli, Ng'andeveimwe and Ng'atuva in support of the same point argued that, sometimes the baby comes too quickly such that the woman could not reach the health facility. In such situations the woman had no other alternative but to seek services of a TBA even when she had planned to deliver in a health facility.

Additionally, Ng'atuva further shared her experience as indicated in the following extract:

*A woman might also change her mind to deliver at home instead of delivering in a health facility because of cordial relationship with the TBA and family members. Nevertheless, if complications arose during labour there was no option but to seek assistance in a health facility. For example, one of my clients had planned to deliver in a health facility but during labour she asked me to conduct the delivery. In the process, I realized that she was experiencing difficult labour so I decided to accompany her to the health facility where she delivered safely, [TBA. Informant].*

Ng'akalungu concurred with Ng'atuva and Ng'anduna that, it was likely for a pregnant woman to change her plan of delivering her baby in a health facility and opt to deliver at home as she puts it, *"Women plan to deliver in a health facility but change to deliver at home because the home environment is favorable since there is support and concern by relatives. Some women will only choose to deliver in a health facility when they realize that there is a problem that cannot be handled at home"*, she said. Ng'akulikya was in a dilemma regarding change of plan from health facility to home delivery. She said, *"Some women decide to deliver their babies in a health facility and finally choose to deliver at home. I do not know why they change their mind. Others choose to deliver at home because they do not attend ANC making it difficult to be accepted in any health facility"*. On the other hand, Ng'andike and Ng'anzula held the opinion that some pregnant women would change their plans of delivering their babies in a health facility because they thought TBAs were experienced and felt safe in their hands. Other pregnant women would deliver their babies at home even though they had decided to deliver in a health facility due to lack of money for transport.

What is observed in the above discussion regarding what may influence a pregnant woman to change her plans from delivering in a health facility to deliver at home would be; precipitated labour, cordial relationship with the TBA, favorable environment at home as a result of support by relatives, lack of money for transport to the health facility and lack of health card.

In response to another question to assess the influence of the husbands, the TBAs were asked; **can a pregnant woman deliver in a health facility against her husband's wish to deliver at home?** This question was asked to explore whether pregnant women had some degree of autonomy regarding place of delivery. In answer to this question, Ng'anduna, agreed that a pregnant woman could deliver in a health facility against her husband's wish. She cited a case where a husband insisted that his wife should be assisted by a TBA but the wife wished to deliver in a health facility. She said, *"The pregnant woman came to my house and I walked her to the health facility. I stayed with her in the health facility for 2 days till she gave birth and was discharged"*, said Ng'anduna. In support of these views of Ng'anduna, Ng'akalungu and Ng'akulikya affirmed that a pregnant woman could deliver in a health facility even when her husband was against it. *"This happened when the pregnant woman had her own resources"*, concluded Ng'akalungu. However, Ng'akulikya maintained that the woman could deliver her baby in a health facility but the TBA had to intervene to persuade the husband to accept the wife's choice. Notwithstanding the views of the above TBAs, the rest 5 disagreed with the above views and firmly maintained that a woman could not possibly go against her husband's wish. For instance, Ng'amuli affirmed that a married woman could not go against her husband's decision. To elaborate this further, she cited the following case:

*A certain pregnant woman planned to deliver in a health facility but the husband refused to let her do so. She packed a few of her belongings and came to ask me to accompany her to the health facility. Since I did not want to cause a conflict in her family, I urged her to comply with her husband's directives. However I prepared her on how to await for the baby by having a new razor blade, clean cord ligatures for tying the baby's cord, a clean mattress and a clean bed sheet. I advised her to ensure that the baby's cord was tied 3 times and demonstrated to her how to separate the cord from the placenta. I also demonstrated to her how to deliver the placenta and*

*how to examine it to ensure that there were no retained pieces of the placenta in the uterus. The pregnant woman went back to her house and when she realized that she was in labour she informed her husband and requested him to call a TBA. The husband went and never came back until the following morning without a TBA. Fortunately the woman delivered safely all alone at night, [TBA. Informant].*

The researcher cannot fail to ask, if the above woman had not gone to consult the TBA who instructed on how to conduct her delivery, what could have happened to her when labour began and the husband had already left her alone at night? Probably she would have lost her life and the baby's too. Ng'andeveimwe had similar views with Ng'amuli who pointed out that, the husband had the final say regarding where the baby would be delivered. If the woman wanted to deliver in a health facility, probably she could persuade her husband to accept her point of view. Ng'atuva conceded that a woman cannot deliver in a health facility without her husband's consent. She could only do so if the situation warranted referral to a health facility. Although Ng'andike felt that a pregnant woman could not go against her husband's wish, she believed that she had an obligation to convince the woman's husband to allow his wife to deliver in a health facility as she wished. Ng'anzula sharing similar views as well indicated that, though she believed a pregnant woman could not go against her husband's wish, she felt she could intervene in case of a need to facilitate the pregnant woman's referral to a health facility.

From the above narrations, the TBAs raised key tradition issue where a married woman could not contravene her husband's wish. It seems like the TBAs are the ones who maintain the transition of husband power and control. A desired sex of a baby can be instrumental in choice of place of delivery as viewed by a nurse interviewed in this study. The following question tested this hypothesis. **Does the anticipated sex of a baby influence the pregnant woman's choice of place of delivery?** In agreement, all the 8 TBAs said that the sex of the baby did not influence choice of place of delivery. In fact Ng'andeveimwe and

Ng'andike added that a child was a blessing from God and the baby's sex should not create a difference regarding place of delivery. From these responses, it was clear the sex of the baby did not influence place of delivery. But the paradox is that the sex of the child may not be known before or at the time of delivery especially for non-ANC-attendees.

To determine if pregnant women waited until the last minute, the TBAs were asked, **do you have prior link with pregnant women who come for delivery?** In response, Ng'andike and Ng'amuli pointed out that they had contact with pregnant women prior to conducting the deliveries. But they lamented that there were those women who came the last minute. For instance Ng'andike said, *"I have contact with pregnant women, but there were those who came the last minute which was not good. When pregnant women come unexpectedly I might not know the position of the fetus or the health status of the woman. When the position of the baby and the health status of the woman are not known in advance, any advice given thereof can be limiting"*.

Sharing her views on the same matter, Ng'amuli postulated that although she made contact with pregnant women, it was not on regular basis. She observed that some women came only when they were in labour but she assisted all of them. *"It did not matter if we had any prior interaction or not, it was all about delivery"*, she said. The rest of the respondents, like Ng'amuli, did have contacts with pregnant women but not on regular basis. Ng'anzula pointed out that sometimes women came when they were in labour and she assisted them. But she usually preferred to have women who had frequently been coming to see her because at least she knew their situation better that is, the position of the baby in the uterus which gave her an idea of the type of delivery expected.

She further observed that for the pregnant women who only came during labour, she could not know their condition in terms of the position of the baby and the wellbeing of the woman. She shared a case of a woman who did not have prior contact to demonstrate how challenging the situation could be:

*I was called by relatives to assist a certain woman who was in labour. This woman had never come to see me before regarding her pregnancy. All the same I agreed to conduct the delivery because she was about to give birth. This woman had no money for transport in case of any eventuality, no clothes for the new born neither was there any food in the house. Little did I know that she was expecting twins which are usually complicated to deliver at home. The first twin was born without complications and survived but the second was born asphyxiated (difficulties in breathing) and died immediately after birth. The placenta was retained and the woman started bleeding excessively. Although I was able to deliver the placenta, the woman also died immediately after that because she lost a lot of blood, [TBA. Informant].*

Ng'andeveimwe, Ng'atuva, Ng'akulikya, and Ng'anduna shared similar concerns with the above respondents regarding irregular contacts with pregnant women. These TBAs maintained that their first contact with some pregnant women was when they were in labour or ready to give birth. Despite what has been said above, Ng'akalungu did not have any link with the pregnant women because she did not conduct deliveries anymore. She pointed out that TBAs were discouraged from conducting home deliveries by Ministry of Health, Kitui due to HIV/AIDS scourge. Nevertheless she conducted emergency deliveries to save life.

To establish if the TBAs were aware of possible complications that could occur during childbirth, a question was posed to them, **are you aware of any problems that can occur during childbirth?** Seven (88 percent) out of the 8 TBAs were aware of some problems that could occur to a woman during childbirth. According to Ng'akalungu, a woman in labour could vomit, pass diarrhea, and bleed excessively before and after delivery and sometimes the placenta could be retained after delivery. On the same note, Ng'akulikya added that a pregnant woman could be too weak to push the baby out of the womb while Ng'andike was aware that a pregnant woman could suffer from prolonged labour and

excessive bleeding after delivery. Ng'akulikya supporting what Ng'andike said, expounded on the seriousness of excessive bleeding after delivery by sharing the following experience; *I conducted a delivery of a certain woman who started bleeding excessively immediately after birth. Upon examination of the placenta and the membranes, I discovered that there were retained after births which could have been causing the bleeding. I set myself to remove the retained membranes, after which the bleeding stopped, [TBA. Informant].* Ng'akulikya did not stop at her experience of excessive bleeding of a woman after delivery but she further pointed out that breech presentation was a common problem to TBAs during childbirth. Ng'atuva in support of what Ng'akulikya said, pointed out that breech delivery was complicated because a baby could die during birth. She further added that delivering twins was complicated too. To clarify her point she shared the following experience as under:

*I had a case whereby I was conducting a delivery; little did I know I was expecting to deliver twins. The first twin presented itself with the face and I tried to deliver this baby which was so difficult for me. The baby was born tired with swollen face and did not cry and passed on shortly after birth. The 2<sup>nd</sup> twin was breech but I managed to deliver it though it was a stillbirth. I would have referred this pregnant woman to a health facility on the onset of labour but it is common knowledge that without ANC card she could not have been accepted, [TBA. Informant].*

Four TBAs further highlighted problems that could occur to a baby during childbirth by sharing their experiences. Ng'andeveimwe explained that sometimes assisting deliveries could pose a challenge to a TBA. In her case she was conducting a delivery at home whereby the process of delivering the baby was normal but what happened at the end was that the amniotic sac containing the baby came out intact. She could see the movement of the tiny baby inside the sac but she did not know what to do. Finally she decided to puncture the sac to let the baby out. To her surprise when the amniotic fluid drained out the baby also died. She could see the baby was premature because of its small size.



Ng'akulikya discussing some of the complications that could occur to a baby after birth, pointed out that, a baby could bleed to death through the umbilical cord if it was not properly tied. She further claimed that a baby could swallow amniotic fluids which could block the airway causing difficulties in breathing and death if nothing was done. This assertion by Ng'akulikya concerning difficulties in breathing of a baby after delivery was in agreement with Ng'atuva, Ng'amuli, Ng'anzula and Ng'andike who pointed out that a baby could experience difficulties in breathing immediately after delivery because of swallowing amniotic fluids and pass on.

It was expected that awareness of these complications by the TBA would make her to advice pregnant women to make informed choices of place of delivery based on their situation. Yet TBAs continued to conduct deliveries at home despite the fact that women and babies lost their lives.

A question was posed to the TBAs to get their views regarding what actions they took if a pregnant woman faced problems during childbirth at home. The question asked was, **what happens in the event that the pregnant woman cannot deliver at home?** This question further gauged the effectiveness of a TBA in circumstances that warranted immediate action. In answer to the above question, Ng'atuva and Ng'amuli said they would inform the mother-in-law who was expected to contact the husband of the woman who was in labour to organize for transport or come to a consensus on what to do. If the woman was not married Ng'amuli would take a step further and inform her mother to organize the logistics of going to a health facility. Ng'andike on the other hand would share the problem with the husband because he had the final say about what was to be done next. *"In some cases I have realized that neither the pregnant woman nor the husband have prepared for any emergency. I have observed that they start borrowing money for transport when the woman was really in danger"*, she said.

Ng'akulikya shared similar views by contending that many a times the woman including family members were not usually prepared for such eventualities because sometimes it took quite a while to get money for transport.

Ng'anduna and Ng'akulikya said that they would inform the family members; give them the reasons why the woman could not deliver at home and accompany the woman to a health facility. For Ng'akalungu, she would give the report to the relatives of the pregnant woman so that they organize for transport if the health facility was far. *“Otherwise if transport was not available and the health facility was within reach, I and the relatives of the pregnant woman would walk slowly with her to the health facility. Sometimes I used my own resources if I found that the woman had not saved any money for contingency”*, said Ng'akalungu. Ng'anzula would accompany the pregnant woman and her relatives to a health facility like Ng'akalungu. If the woman could not deliver at home, Ng'andeveimwe would refer her to a health facility or call the nurse to come for assistance. *“However referral in such a context has its challenges. It is possible to refer the pregnant woman to a health facility only to discover that she was not prepared for such an eventuality. This is evidenced by the helter - skelter way of doing things, such as borrowing money at the very moment the TBA declares normal delivery is not possible and sometimes life is lost”*, she said.

In an effort to determine whether TBAs had knowledge that could contribute to the wellbeing of pregnant/postnatal women, the study asked the TBAs the following question; **do you give any advice about childbirth to pregnant/postnatal women when they come to see you?** The responses to the answer were extensive and informative as narrated. Ng'anduna and Ng'akalungu had elaborate accounts on the advice they gave to pregnant women. For instance, Ng'anduna advised pregnant women on personal hygiene, the best sleeping position to avoid making the fetus uncomfortable, to avoid strenuous work and to avoid standing for

long hours. If the legs of the pregnant woman were swollen, Ng'anduna took silks from green maize, boiled it and gave the fluid to the woman to treat the condition. She also palpated the abdomen of the woman to know how the fetus was lying in the uterus. In case the fetus was mal-positioned, she performed manual positioning to bring the fetus to a normal position. She also listened to the fetal heart. Like Ng'anduna, Ng'anzula also palpated the women and gave them advice about personal hygiene and eating balanced diet such as beans and maize. Ng'akalungu on her part encouraged pregnant women to attend ANC and examined them to check if they were anaemic. Her full account was captured as under:

*In the case of anaemia, I advised the woman to eat more of nutritious food such as milk, meat, vegetables, eggs, beans and fruits. For swollen legs, I advised her to rest her feet on an elevated position like on a stool to increase blood circulation. If a woman had varicose veins, I referred her to a health facility because there was a danger of bleeding profusely if the veins were pricked, [TBA. Informant].*

Considering the advice given by Ng'akalungu to pregnant women, the researcher was prompted to enquire from her whether she was trained because the advice she gave was advanced. In affirmation she said yes, she was trained by Ministry of Health Kitui, in 1990's.

Like Ng'anduna and Ng'akalungu, Ng'andeveimwe advised pregnant women about the best position of sleeping to avoid stressing the fetus. Like Ng'anduna, Ng'andike also palpated the pregnant woman's abdomen to ascertain the position of the fetus and then advised the pregnant woman accordingly. Ng'akulikya informed pregnant women that ruptured membranes was a dangerous sign in pregnancy since it could cost the baby's life and gave them the signs of how they could recognize this condition. Ng'atuva advised pregnant women to save some money for transport in case of any emergencies such as early ruptured membranes. Ng'amuli did not give any advice to the pregnant women.

Regarding postnatal women, Ng'anduna taught them about personal hygiene, the type of food (milk, beans, meat, maize, sorghum, and finger millet) they should eat in order to increase blood supply in the body to replace what was lost during delivery and to increase

breast milk. She further advised the postnatal women to exclusively breast feed the baby for 6 months since breast milk was the best for the baby. She advised them to keep the baby warm at all times in order to avoid pneumonia. Ng'andeveimwe advised postnatal women against holding the baby upside down. She also advised them to avoid bathing the baby few days after delivery and only use cotton wool dipped in oil to wipe the baby's body and to keep it warm all the time.

Similar ways of bathing the baby and keeping it warm as mentioned above were also shared with pregnant women by Ng'andike. Ng'andike further advised postnatal women to take panadal tablets in case they were in pain and taught them how to keep the baby warm. Ng'akulikya listened to the complaints of the postnatal women and advised them accordingly. For Ng'amuli, she advised postnatal women to drink milk after delivery to relieve abdominal pain which occurs after delivery. Ng'akalungu advised postnatal women to keep the baby warm always and taught them the best way to position the baby while breastfeeding and to exclusively breastfeed it for 6 months. She also encouraged them to feed well as well as keeping the baby clean. Ng'anzula and Ng'atuva did not give any advice to postnatal women. Surprisingly from this finding it is notable that only one TBA encouraged pregnant women to attend ANC and only one advised them to save money for transport in case of need.

The study posed another question to the TBAs; **if there was a problem during labour or after delivery and family members were reluctant to take action, could they intervene?** This question was asked to establish the command a TBA had in influencing decisions regarding childbirth at family level. In response to this question, the TBAs said they could intervene. Their answers were also broad and enlightening.

For instance, Ng'andeveimwe had this to say:

*A certain pregnant woman whom I had not known in advance came to me when her time for delivery was due. After a brief examination, I realized that I was not able to conduct the delivery. When I brought my concern to the family members they seemed not to bother. Faced with this situation, I decided to take the responsibility and accompanied the woman to a health facility where she eventually delivered safely , [TBA. Informant].*

Four other TBAs said they would involve mothers-in-law, husbands or parents and make sure the pregnant woman was taken to a health facility. They all concurred that they would talk to a family member especially the mother-in-law and the husband or the parents if the woman was not married and inform them why the pregnant woman should be taken to a health facility. In case they refused to take action, Ng'anduna would involve the village administration although she has never done so because the family members usually listened to her. Ng'atuva would involve the village elder and the chief if need be if no action was taken. If no foreseeable action was forthcoming the 4 TBAs indicated that they would use their own resources. In this regard, Ng'anduna said, *“If the family members are not supportive especially when the husband disowns the pregnancy, I will use my own resources to help the woman but we agree on how she will refund whatever money I spent”*. Ng'akalungu shared the same views with Ng'anduna. She pointed out that if family members were not willing to transfer the pregnant woman to a health facility, she would use her own resources to ensure that she got to a health facility for help. Later she would negotiate with the parents on the modalities of paying back her money. Ng'atuva would also use her own resources to assist the woman. She did not talk of reimbursement of the money she would have used to help the woman. Ng'andike said she would inform the family members about the situation and insist to be told what should be done while Ng'anzula would do everything to ensure that the mother and the baby's lives were safe. She postulated that a TBA was powerful and family members would listen to her advice.

Out of the 8 respondents, only one said that she would leave the matter to the family members to make a decision so as to avoid being part of any consequences thereafter. Drawing from the above discussion, it is clear a TBA can influence decisions regarding childbirth at family level as summarized by Ng'anzula who pointed out that a TBA was a power to reckon with.

This study enquired from the TBAs their views about **what pregnant women say regarding delivering in a health facility**. The reason for asking this question was to establish the relationship between pregnant women and the nurses. Interestingly, the TBAs had similar views about the relationship between pregnant women and nurses. According to Ng'anduna, her interactions with expectant women shows that they preferred to deliver at home because they felt supported by their relatives and friends during childbirth. Furthermore, they claimed that they were left alone in the labour ward, and the nurses told them to call them when they were ready to deliver. When that time reached, the nurses were nowhere to be found. Ng'akalungu and Ng'akulikya shared similar sentiments about the nurses' negative attitude towards pregnant women. Ng'akalungu added that the relationship between the nurse and the woman in labour was not warm as she observed:

*A pregnant woman sometimes may be left alone in the labour ward to deliver alone while the nurses may be chatting in the ward. Most women prefer to deliver at home because there is support from relatives and the TBA. This support includes massaging the back and the abdomen, a provision of warm drink during and after delivery, [TBA. Informant].*

In view of the above discussion, all the other TBAs concurred that pregnant women viewed nurses as hostile and rough especially during palpation and in the labour ward where women were castigated and sometimes beaten. Therefore women feared to deliver in a health facility and preferred to deliver at home where there was support and tender loving care from the TBA and other relatives.

Ng'atuva, Ng'andike and Ng'amuli said that women feared to deliver in a health facility because of caesarean section. These respondents said that some women had a belief that if they chose to deliver in a health facility, they would undergo cesarean section even when it was not necessary. Nevertheless, Ng'andeveimwe had different views concerning what pregnant women said about giving birth in a health facility. She pointed out that, some women felt that it was better to deliver in a health facility because of the comprehensive services available. Seven (88 percent) of the TBAs in the preceding discussion indicated that, nurses had a negative attitude towards pregnant women. Based on these assertions by the TBAs about what pregnant women say about delivering their babies in a health facility, can influence their choice of place of delivery. Of particular interest is the negative attitude of nurses' towards pregnant women. The next question explored whether TBAs were aware of pregnant women's reproductive rights?

The study asked the TBAs **if they were aware of pregnant women's reproductive rights**. Surprisingly, all the 8 TBAs said that they were not aware of such rights. In this connection Ng'amuli said, *"For me, you are the first person I have heard talk about women's rights concerning pregnancy and childbirth"*. *"In matters related to pregnancy and childbirth and according to Akamba culture, it is the prerogative of the husband because he knows how many children he wants to have and where they should be delivered"*, observed Ng'anduna.

To get responses from the TBAs; they were asked, **which category of women is likely to deliver at home and why?** Ng'akulikya felt that women who were likely to deliver their children at home were daughters and daughters in law of mothers who had delivered their children safely at home. She said that some parents encouraged their daughters and daughters in law to deliver at home especially if they had never experienced any problems during childbirth. According to Ng'akulikya, some women will say; *"My mother delivered*

*all her children at home and nothing wrong happened therefore I will also deliver at home*". Ng'amuli supporting views of Ng'akulikya postulated that women who had delivered one or more children without childbirth complications were likely to deliver their babies at home. This view was also shared by Ng'anduna who observed that women who had delivered 2 children and above, either in the hospital or at home without any difficulties related to childbirth were likely to deliver at home. Interestingly, the same view was shared by 3 other TBAs; Ng'akalungu, Ng'andeveimwe and Ng'andike who maintained that women who had no previous problems during childbirth were likely to deliver at home. Ng'andike stressing her point on the same issue said, *"Women who had delivered several children without any complications were likely to deliver at home"*. Surprisingly, Ng'akulikya pointed out that, some women regardless of age preferred to be delivered by a TBA who was famous in the village. According to Ng'amuli, women who conceived before marriage or dropped out of school were likely to deliver at home. The reason for this was that these pregnant women did not want their neighbors to see them in ANC. Likewise, Ng'anzula conceded that unmarried pregnant women chose to deliver at home to avoid stigma from the community. However, Ng'andike added that, women who had not attended ANC were likely to deliver at home since there was a common belief that any pregnant woman without ANC card could not be accepted in a health facility at the time of giving birth. For Ng'atuva, pregnant women who were afraid of undergoing cesarean section would prefer to deliver at home.

The TBAs have clearly stated from the above discussion that women who had previous safe deliveries either at home or in a health facility were likely to choose to deliver their babies at home. In their discussion, they indicated that such women did not perceive any childbirth problems that could happen during the time of delivering their babies. Other categories mentioned included; women who conceived before marriage, school drop outs and pregnant women without a health card. The study further posed this question to the TBAs; **do**



**you have any connection with nurses regarding your role as a TBA?** This question helped to check if TBAs interacted and networked with the nurses. Five (63 percent) out of the 8 TBAs namely; (Ng'anduna, Ng'akalungu, Ng'akulikya, Ng'andevimwe and Ng'anzula) said that they had contacts with nurses. Ng'akulikya said that, when a pregnant woman experienced complications during labour; she accompanied her to a health facility and handed over the case to the nurse. Many times she took pregnant women to the health facility to be assisted to know the position of the fetus which was very important because during delivery the head of the fetus should be presenting. Ng'akalungu and Ng'andevimwe had similar views about their contact with the nurse. When they accompanied pregnant women to a health facility, the nurse taught them about their roles as TBAs and the need to refer pregnant women to a health facility where there was good care and trained medical staff.

Ng'anduna made contacts with the nurse in case of a problem because the health facility is within reach while Ng'anzula was advised accordingly by the nurses that, if there was any problem regarding pregnant women she should accompany them to the health facility. Interestingly, the other 3 respondents; Ng'atuva, Ng'andike and Ng'amuli had no connection with nurses. Ng'amuli said that she did not have any connection with nurses even when she accompanied pregnant women to a health facility. She revealed that she did not identify herself as a TBA to the nurses because the MOH had forbidden them from practicing their trade. Ng'andike had no connection with the nurses since she was not trained while Ng'atuva simply said she had no connection with nurses and did not want to talk about the issue.

The revelation in the above discussion is that, majority (63 percent) of the respondents had connection with the nurses which is a good sign regarding collaboration. When TBAs interacted with nurses about safe motherhood, the former were likely to improve their performance in conducting deliveries.

### 6.3 Results of the Nurses

Having gathered information from TBAs about their perspectives regarding pregnant women, the next discussion focused on perspectives of nurses towards the same issue. The same questions that guided the discussion with the TBAs were also used on the nurses. However, the nurses were asked an additional question on policy regarding the role of TBAs.

To capture responses regarding choice to deliver at home, the nurses were asked, **do you think there are times a pregnant woman plans to deliver in a health facility but later on chooses to deliver at home?** In their responses, the nurses came up with pertinent factors that influence pregnant women to deliver at home. For instance, N1 and N3 felt that some women delivered their babies at home despite the fact that they had planned to deliver in a health facility because of poor road networks and especially when they lived far away from the health facility. N1 pointed out that in such a case the available means of transport was by a motor cycle which might not be convenient for a woman in labour. She further observed that a woman experiencing quick labour at home could not possibly reach the health facility on a motor cycle. N2 and N5 were in agreement with N1 about the likelihood of precipitated labour making a woman to deliver her baby at home. Contributing her views in response to the above question, N4 added that a pregnant woman could change her decision from delivering her baby in a health facility if she was not aware of the advantages accruing from delivering a baby under the care of professional medical staff.

To establish whether the gender of a baby determined place of delivery, the study asked the nurses; **does the anticipated gender of a baby influence choice of place of delivery?** According to N1, choice of place of delivering the baby was not influenced by the anticipated sex of the baby in anyway. N3 and N4 concurred with N1 that awareness of sex of baby was not a factor to influence choice of place of delivering the baby. Nevertheless, N2

and N5 had different views concerning this issue. N2 indicated that if a pregnant woman had been longing to have a baby boy or, a baby girl and she happened to know the sex of the baby through a scan, she was likely to choose to deliver in a health facility. This was to ensure the wellbeing of the baby. N2 affirmed her claim by adding that, names such as Precious; Blessings and Lucky were common in such cases of preferred gender of the baby. From the views of the nurses, 60 percent of them agreed that the gender of the child did not influence choice of place of where the woman would deliver while 40 percent agreed that knowledge of sex of a baby could influence a woman's decision of where to deliver the baby.

To get responses concerning collaboration with TBAs, the study posed this question to the nurses; **do you interact in any way with the TBAs?** This question was to gauge the level of interaction between nurses and TBAs. Interestingly, nurses did not meet TBAs occasionally. According to N1, the only time medical staff met TBAs was when they brought a pregnant woman who was in labour and had some difficulties in childbirth at home. As she narrates:

*In the health facility, nurses usually take the opportunity to acknowledge the work of TBAs and also receive the patient immediately. The nurses also give TBAs a one to one health talk as they wait for the patient to be attended. One of the key issues discussed during this talk is encouraging TBAs to refer pregnant women to a health facility instead of retaining them at home. During this interaction, the TBA is given an opportunity to seek for clarification in areas pertaining to childbirth, [Nurse Informant].*

Asked if the nurses reach TBAs in the community; N1 said:

*TBAs are in contact with CHV who are trained in areas of community health including reproductive health. These CHVs are allocated a number of households where they are expected to know each household thoroughly, such as the number of pregnant women, number of TBAs, number of children who are below 5 years and number of postnatal mothers. The role of the CHV is mainly to give health education and to encourage those who are sick to seek medical help. The CHV also educates TBAs and discourage them from conducting deliveries at home to avoid the danger of contracting HIV.*

*In addition to the above information nurses also educate TBAs during public meetings about their role. TBAs are informed that their role entails advising pregnant women on personal hygiene, good diet and encouraging them to attend ANC, [Nurse Informant].*

N1 continued to point out that there were occasions when nurses intervened when they realized that a TBA was conducting deliveries at home and majority of the babies died at childbirth. A case at hand was about one TBA who claimed that her art of assisting women during delivery was a gift from God. This TBA would only refer cases to a health facility of either mother or baby at the verge of death. Through this TBA, so many lives were lost. As a result of this worrying situation, the nurse in charge of the nearby facility through the area chief organized for a public meeting and invited this TBA. During the meeting, the nurses had the opportunity to educate the people about the importance of delivering in a health facility and the limitation of a TBA. The TBA who claimed to have a special gift of assisting women during delivery vowed not to continue doing the same and instead would refer pregnant women to the health facility because she was now enlightened. The TBA kept her promise and as a result maternity cases were referred to the health facility in good time.

In support of the views of N1, N2 and N5 said that when TBAs accompanied pregnant women to the health facility to ensure that they start the process of attending antenatal clinic, the nurses took the opportunity to advise them about their roles and limits as per the government policy. The policy stated that all deliveries should be handled by skilled personnel unless it was an emergency case.

N5 further added that when relatives brought a pregnant woman for delivery in the health facility, nurses enquired if a TBA was among them. If the answer was positive they took time to discuss with the TBA about issues related to her role and her limitations in respect of her work. However, N4 did not interact with TBAs.

N3 said that when pregnant women came for delivery accompanied by relatives, she enquired if there was a TBA among them, interestingly, even if a TBA was among them, she did not identify herself. N3 added that the reason for this behavior could have been that most of them were aware that they should not conduct deliveries at home. It is observable from the above discussion that both nurses and TBAs were striving towards one goal of safe delivery of children. Therefore to interact meant to collaborate with a view of helping the pregnant women to be safe during delivery.

To gather information regarding which group of women would use maternity services, the nurses were asked, **which category of pregnant women is likely to deliver in a health facility and why?** In response to this question, N2 and N5 postulated that women expecting their first baby and those who had dropped out of school were most likely to deliver their babies in a health facility. This was not in agreement with the views of the TBAs. According to the TBAs, the young women expecting their first babies and the school dropouts were afraid of stigma and opted to deliver at home. However, according to N1, school dropouts were likely to deliver at home in order to spare money for transport and buy new clothes for the infant. Nonetheless, N5 had different views about pregnant women who had dropped out school. She pointed out that, unmarried pregnant women who were school dropouts and whose parents were enlightened, were likely to deliver in a health facility. N2, N3 and N4 conceded that women who faced problems during childbirth were likely to deliver in a health facility. N2 further indicated that, some pregnant women could decide to deliver at home and only go to the health facility when they were faced with difficult labour as narrated in the case below:

*A certain pregnant woman decided to deliver at home. But she faced problems as she developed difficulties in breathing because her blood pressure went up. She was prayed over by a pastor without improvement. A witch doctor treated her for quick delivery but she was not able to deliver the baby. The third day her whole body was swollen and she could not feel the baby's movements. Neighbors requested me to*

*intervene in order to save the woman's life. I asked the husband to bring her to the health facility but he was unwilling to do so because he believed his wife was bewitched. I approached the mother-in-law who agreed to bring the pregnant woman to the health facility. Her life and the baby's were saved through cesarean section though the baby was born premature [Nurse Informant].*

Supporting the contention of N2, N3 argued that, women who encountered childbirth complications regarded the services in the health facility as comprehensive and so they felt safe to deliver there.

N1 maintained that pregnant women who were married were likely to deliver in a health facility because they received support from their partners. These views were also supported by N4 who argued that women who were married and had support from their spouses and family members were likely to choose to deliver in a health facility.

According to the narration of the respondents the following categories of women were likely to deliver in a health facility; first delivery, married women, those pregnant women with experiences of previous childbirth complications and finally those who were referred by TBAs when they could not deliver at home. The assertions by nurses regarding category of women likely to deliver in a health facility were in agreement with what the TBAs said earlier regarding the same aspect.

After examining critically the categories of women who were likely to deliver in a health facility, the researcher wondered if pregnant women were aware of their reproductive rights. To find out if pregnant women were aware of their reproductive rights, a confirmation was sought from the nurses by asking them, **are the pregnant women aware of their reproductive rights?** N1 said that just a few pregnant women knew their reproductive health rights while majority were not aware of such rights. She continued to point out that the decisions of pregnant women, who were not aware of these rights, were to a large extent influenced by their parents, mothers-in-law and their husbands.

As N1 explains:

*Some pregnant women will seek advice from their husbands regarding place of delivering the baby and stick to the guidance given irrespective of the consequences. Some other pregnant women will go to an extent of waiting for their husbands to sign for them the medical operation form if they were required to undergo caesarean section. Staff from our health facilities tries to take some time to educate the pregnant women on these rights but the challenge is the time constraint because of workload on our part. My recommendation in this regard would be to request the government to engage another organization which is more vibrant to reach communities to educate them about these rights, [Nurse Informant].*

According to N3 and N4, majority of the pregnant women were not aware of the rights though they tried their best to teach basic rights to those they came into contact with, but sometimes they experienced work constraints. N2 maintained that they taught pregnant women about these rights by telling them it was their right to choose where they wanted to deliver their baby. This also included signing medical forms by themselves without involving a second party. Nevertheless, some pregnant women who were totally controlled by their husbands and mothers-in-law were unaware of these rights. In spite of the above assertions, there were few exposed and educated husbands who allowed their wives to choose where they wanted to deliver their babies and supported them. N5 added that some of the pregnant women were aware of these rights since the nurses enlightened them when they attended ANC. N5 further observed that majority of the women seemed not to be aware of their reproductive rights. This was observed in their inability to sign medical forms in the absence of their spouses.

From the nurses' perspectives, it is clear that most pregnant women were not aware of their reproductive rights. When a pregnant woman is unaware of her reproductive rights, her decision regarding place of delivering the baby is limited which could affect her and the baby negatively, besides her autonomy is likely to be compromised.

Having established that most pregnant women were not aware of their reproductive rights, the researcher sought to find out if then the nurses advised pregnant/postnatal women

about childbirth. In an attempt to determine if nurses had time to discuss issues related to childbirth with the pregnant/postnatal women a question was posed, **do you advice antenatal/postnatal women about childbirth?** All the 5 nurses confirmed that they advised pregnant and postnatal women on issues regarding maternal health. For instance, N1 and N2 said that when pregnant and postnatal women came to the clinic, nurses advised them on eating balanced diet and personal hygiene and informed them about risks or emergencies that required medical attention. These emergencies included; broken membranes, high blood pressure and bleeding before and after delivery. N1 continued to point out that, the women were also taught about the importance of attending ANC and postnatal clinic including advantages of delivering in a health facility. Postnatal women were advised to keep the baby warm and observe it to detect any sign of problems for early action. Along with this information, the pregnant women were taught how to prepare themselves in readiness for the forthcoming baby. Each pregnant woman was provided with a free booklet where all the important information was contained about pregnancy and childbirth. N2 stressed that postnatal mothers were particularly taught about exclusive breastfeeding for 6 months, personal hygiene, nutrition, and family-planning methods. N3 concurred with N1 and N2 on the advice given to both antenatal and postnatal women. She pointed out that when pregnant women attended ANC, nurses advised them to eat plenty of fruits, vegetables and to drink plenty of water. These women were further advised to ensure that they slept under a mosquito net which was treated to avoid possibility of catching malaria and to avoid heavy work. N3 further conceded that nurses also brought to the attention of pregnant women the danger signs of pregnancy such as bleeding before delivery and early rupture of membranes. N4 and N5 concurred with what the nurses taught pregnant and postnatal women. The other aspects added by these 2 nurses were; danger signs of pregnancy, getting tired easily, swelling of the face and hands and breathlessness. According to the views of N4 and N5, all these signs



called for medical help. N5 added that, on the part of preparedness for delivery, pregnant women were advised to have some money for unforeseen emergencies such as transport.

A further assertion by N1 was that to compliment the need to deliver in a health facility, the medical staff were motivated accordingly. For instance there was the global fund (Result based funding) whereby Ksh900 was awarded for every delivery in a health facility. Out of this money 60 percent went to pay medical staff as motivation and 40 percent was for the improvement of the health facility. On the part of the government, Ksh 2500 was given for every delivery in a health facility which amount went towards improvement of the health facility. Despite the awareness created by nurses regarding possible complications during childbirth and incentives by the global fund and the Kenya government, majority of women still delivered at home. This is evidenced by the fact that 39 percent of pregnant women in Kenya deliver at home as earlier indicated in this study.

This Study enquired from the nurses their perspectives concerning **what pregnant women say regarding delivering in a health facility**. In response to the above question, N1 said that some pregnant women appreciated the services provided by nurses. They claimed that delivering in a health facility was good because they received tender loving care from the nurses. On the same thought, N3, N4 and N5 said that some pregnant women preferred to deliver in a health facility for various reasons. For instance, some women said that the health facility environment was clean and the services were comprehensive such that any complication related to childbirth could be managed effectively. The nurses further pointed out that some pregnant women liked to deliver their babies in a health facility because it was a conducive environment. According to the women, a health facility was a good place because they were given water to bathe and the baby was cared for.

According to the nurses, the pregnant women also said delivering in a health facility had many advantages such as lessons about breastfeeding, good nutrition, personal hygiene and family-planning methods. N2 in support of what the above respondents said, she pointed out that some women were happy to deliver their babies in a health facility because maternity services were free of charge.

On the other hand, N1 observed that some of the pregnant women in the low income bracket might choose to deliver at home because of transport cost whereas other pregnant women might lack support from their partners and opt to deliver at home. On the converse, according to N1, some women claimed that they preferred to deliver at home because some nurses were harsh to them. For instance, some nurses abused and shouted at the pregnant women when they came to deliver their babies in the health facility. These sentiments were also shared by N5 who indicated that some nurses had negative attitude towards some women especially young girls who dropped out of school because of pregnancy and aged pregnant women who came to deliver in the health facility. The nurses viewed these categories of women as getting pregnant at the wrong time. On the other hand, N2 maintained that some pregnant women said they preferred to deliver at home assisted by TBAs because of cordial relationship with them during childbirth. For instance they massaged the pregnant woman's back and abdomen with coconut oil to relieve pressure caused by uterine contractions. TBAs comforted and encouraged the pregnant woman during labour. *“Majority of women said TBAs were friendlier and engaged women in a more cordial relationship than nurses”*, said N3, [Nurse Informant].

The above discussion has highlighted several factors that could influence pregnant women's choice of place of delivering the baby. These included; attitude of TBAs' and nurses' towards the pregnant women whether negative or positive, the attitude of significant others by supporting or non support and transport availability to the health facility.

To find out if pregnant women who were non-ANC-attendees were assisted during childbirth in the health facility, a question was posed to the nurses, **if a pregnant woman was being attended to by a TBA all through and only comes for delivery in a health facility, would she be assisted?** All the 5 nurses agreed that they did not turn away any pregnant woman who came to deliver her baby in a health facility no matter the circumstances. N2 said the nurses attended to pregnant women despite the circumstances for the sake of saving mother and baby's life because everybody had a right to life. However, after delivery the nurses educated the woman about the importance of attending ANC in future. N3 sharing similar views said that, "women coming to deliver in the health facility are not turned away despite being attended by a TBA all along. Nonetheless after delivery, we advise those who had not been attending ANC to make sure that in future they did so". N1, N2 and N5 said they received all pregnant women without bias but cautioned them against dangers of failing to attend ANC. They nevertheless urged the women to attend ANC in their next pregnancy.

### **6.3.1 A Government Policy on TBAs**

To explore what the government policy entailed as pertains to the role of TBAs in childbirth, the nurses were asked, **is there a government policy regarding what a TBA should know?** In response, all the 5 nurses indicated that there was a government policy regarding what a TBA should know. In this connection, N1 illustrated an elaborated account as under:

*According to Ministry of Health, all pregnant women should be delivered by a skilled person (medical professional) in order to reduce maternal and neonatal deaths. According to the policy, a TBA should refer a pregnant woman to a health facility because of the following reasons; a TBA cannot know some of the complications that could occur to a woman who was in labour such as placenta praevia, may not make a prompt decision, can perform procedures which may be dangerous to the baby and mother such as manual cephalic version (change of baby's position while still in the uterus) which can cause the umbilical cord to coil around the neck of the fetus and complicate normal delivery. A TBA may not be able to know the ability of the woman to deliver normally, she may tell the woman to push the baby out of the womb before*

*time which can cause genital tear leading to fistula and she may not even be able to know how the baby is lying in the uterus [Nurse Informant].*

The rest of the nurses; (N2, N3, N4 and N5) confirmed that there was a government policy that stated that a TBA could only assist deliveries in emergency cases only. Otherwise all maternity cases should be referred to a health facility.

#### **6.4 Summary**

From the discussion with TBAs based on their experiences and observations during childbirth, several determinants of choice of place of delivery emerged. For instance the TBAs pointed out that, the control of the husband over the wife regarding where the baby should be delivered was significant. According to the TBAs, the pregnant women maintained that their husbands had the final say and the onus of deciding where the baby should be born firmly rested on them. In this regard the woman felt obliged to comply. On the same note concerning influence of place of birth, the mother-in-law played a key role whereby in case of any problem regarding childbirth, the TBA had to consult the latter concerning what should be done. Another determinant of choice of place of delivery according to the TBAs was previous safe deliveries. The TBAs' observation in this regard was that, if a woman had given birth to 2 or more children safely either in a health facility or at home, her preference was to deliver at home. The negative attitude of nurses towards pregnant women as described by 75 percent out of the 8 TBAs would be enough to dissuade pregnant woman from delivering their babies in a health facility. These sentiments about the negative attitude of some nurses towards pregnant women were also expressed by 40 percent of the 5 nurse respondents.

## **7.0 CHAPTER SEVEN: STUDY DISCUSSIONS**

### **7.1 Introduction**

This study set out to explore “Determinants of the Choice of Place to Delivery by Expectant Mothers in Kitui West Sub-county”. The first part of the discussion focused on objective one which was to explore from pregnant women the choice of place of delivery and reasons for their choice. This was followed by objective two which was to determine where the women finally delivered their babies and what influenced their choice. The opinions of nurses and TBAs regarding choice of place of delivery for pregnant women representing the third objective of the study, were used to support the views of the pregnant women in this chapter. This discussion presents the findings of the study and comparisons made with reviewed literature.

### **7.2 Factors Informing the Choice of Place of Childbirth**

#### **7.2.1 Complications**

The study found that the majority of the respondents gave birth in a health facility in case there arose any complications which could affect the woman during childbirth. The mentioned possible complications were; excessive bleeding after delivery in case of retained placenta, prolonged labour, to avoid transmission of HIV and high blood pressure during childbirth. Excessive bleeding can be lethal. One of the causes of maternal mortality globally is severe bleeding which may happen after childbirth (Magadi, 2000a, Elo, 1992). Excessive bleeding during childbirth was the leading cause in death in Africa and Asia (Elo, 1992).

In fact between 1997 and 2002 in Kenya, women who died because of excessive bleeding after delivery were 4 percent (Angatia, 2010). This being the case, prompt action must be taken to stop the bleeding by encouraging pregnant women to deliver in a health facility which is adequately equipped.

A further step would be to detect women at risk of bleeding in labour and after delivery and make sure they deliver in a health facility. The community could also be educated on the danger signs of bleeding and urged to take quick action when the need arises (Brandon et al., 1992).

Another factor that the respondents gave as informing their selection to give birth in a health facility was the care and the advice given by nurses. This care included provision of warm water for the woman to bathe, bathing the newborn and application of eye ointment immediately after birth. The advice given included; best breast feeding methods, nutrition, hygiene and safety during delivery. Others included; immunizing the newborn, teaching the respondents how to handle a premature baby, scrutiny of the newborn to ensure that there was no problem or deformity. Another finding was that mothers delivered in a health facility for fear of witchcraft which could cause prolonged labour and excessive bleeding after delivery. The study found that witchcraft played a role in determining a place of delivery. The findings agree with findings of Kumbani et al., (2013) who found that in Malawi, half of the pregnant women interviewed believed that labour could be delayed because of witchcraft if a woman delivered at home. Interestingly, a study done by Ebuehi et al., (2006) in a rural area in Ogun State, Nigeria, showed that pregnant women attending primary health care clinics acknowledged that witchcraft could arise from utilizing TBAs' services and prolong labour process.

The study also found that young unmarried pregnant women in their first pregnancy were reluctant to deliver in a health facility unless they developed complications in the course of labour at home. According to the responses, these women feared the rigors of childbirth and unless they were pushed by their mothers to give birth in a health facility they chose to give birth at home. The responses pointed out that it was important for women who were expecting their first baby to endeavor to give birth in a health facility because they had no experience of childbirth and they were likely to face problems hence women should give birth in a health facility where proper monitoring of childbirth process was done.

A respondent said that she was being assisted by a TBA during delivery but the baby presented itself with the legs instead of the head (breach presentation). When this happened, she was rushed to a health facility but the baby was stillbirth. When the pregnancy is at 32 weeks, the position and presentation of the fetus become more significant. If a breach presentation or an oblique position is therefore detected, it should be presented to a doctor for investigation and correction without delay (Cruz, 1976). Brandon et al., (1992) suggest that due to seriousness of the repercussions of breach presentation, women in such situation must deliver their babies in a fully equipped referral-level facility. If the above TBA who was handling a breach delivery knew better, she would have referred her client to a health facility in good time, but this was not the case. The choice to deliver in a health facility for another respondent was as a result of expecting twins. In her narration, she explained how difficult it was to deliver twins at home. Brandon et al., (1992) had the same opinion with the sentiments of this respondent because these authors recognize also how difficult it is to deliver twins.

In this connection therefore, Brandon et al., (1992) suggest that an abdominal examination of a pregnant woman by an expert examiner can reveal twin pregnancies. If this is established, such cases should be referred to a health facility to avoid obstructed labour.

The Chi-square test analysis showed that giving birth at home depended on the previous safe deliveries (Chi-square test analysis,  $\chi^2=1.701$ ;  $df =4$ ;  $p=0.044$  where  $p \leq 0.05$ , cf. appendix 7 p174); that previous safe deliveries was significantly associated with choice of place of delivering the baby. The findings of this study are in tandem with the findings of Magoma et al., (2010) who established that, elders among Watemi and Maasai communities maintained that pregnant women with no risk factor as confirmed in health clinics should continue to deliver at home because these were 'normal' pregnancies and safe delivery was possible. Kibaru et al., (2006), in support of this discussion assert that, when pregnant women had safe deliveries, it was a sure way of anticipating that all subsequent pregnancies would be the same. Concerning the number of children one had delivered which was likely to influence place of delivery, Kitui et al., (2013) argue that, women who had 4 or more deliveries were 65 percent less likely to deliver in a health facility when compared to those for whom this was the first child. These findings concurred with those of Sunday et al., (2005) who posited that previous safe deliveries were an important factor in determining where a baby would be born. This conclusion by Sunday et al., (2005) was arrived at through a research carried out at the Ebonyi State University Teaching Hospital, Abakaliki, Nigeria. The converse is true that, perceived vulnerability as evidenced in previous deliveries had a great impact on the choice of eventual place of delivery. This pointed out to the fact that the more vulnerable a woman was, the more likely she was to deliver in a health facility.

### **7.2.2 Level of Income**

The study found that the level of income of a pregnant woman did not influence the choice of her place of delivery. Level of income of pregnant women meant that there were broader options of choice of place of delivering the baby. Besides, the study expected level of income of a pregnant woman not to hinder her from delivering in a health facility because maternal health care services were free of charge. The assertions of ANC-attendees and non-



attendees differed from the findings of Tura and Mariam (2008) who indicated in their study that level of income of a pregnant woman influenced her to seek delivery in a health facility. However transport cost could influence a pregnant woman to give birth at home. This is because a pregnant woman needed money to pay for transport in order to access maternity services otherwise if the money for transport was lacking, she could end up delivering at home.

The respondents further ascertained that if a pregnant woman could not deliver at home, she had to be urgently taken to a health facility where money for transport was required. These respondents further pointed out that, pregnant women who lived in the periphery of the health facilities could not possibly walk to the health facilities, so transport cost was unavoidable.

### **7.2.3 Occupation**

The study findings were that occupation of respondents did not influence them in choosing place of delivery. A significant number of respondents maintained that the nature of their work could not influence their choice of where they would give birth. The respondents who were teachers said the Ministry of Education granted maternity leave. Self employed respondents, housewives and those who practised subsistence farming pointed out that they made their own programs on what to do. In case of need, they arranged with other family members or neighbours and friends to give a hand so that they could attend to other important responsibilities including reproductive health issues. These findings were confirmed by the Chi-square test analysis ( $\chi^2=14.012$ ;  $df=14$ ;  $p =0.449$  where  $p \leq 0.05$ , cf. appendix 7 p174) which showed that there was no relationship between occupation and choice of place of where women would give birth.

The same trend applied to the non-ANC-attendees. These respondents claimed that the work they did could not influence their choice of place of giving birth. The Chi-square test analysis illustrated these findings ( $\chi^2=9.633$ ;  $df=8$ ;  $p =0.292$  where  $p\leq 0.05$ , cf. appendix 8 p175). Based on these results regarding occupation and choice of place of where women planned to give birth, majority 79 percent of ANC-attendees and 90 percent of non-ANC-attendees, pointed out that, their choice of place of birth was not influenced by their occupation. However, these findings did not agree with those of Falle et al., (2009) which indicated that there was a relationship between access to professional health care services and occupation.

#### **7.2.4 Age**

The pregnant women with advanced age in this study felt uneasy in a maternal health care clinic. These women feared to be disgraced by women colleagues and medical staff and they therefore preferred to give birth at home. They were afraid of what other pregnant women would say when they saw them pregnant 'at the wrong time'. They feared to be the 'laughing stock' of the village for giving birth at the same time with their young daughters. The aged pregnant women were afraid of neighbours who could be asking why the former chose to be expectant at their age. So they avoided attending ANC and chose to give birth at home. Therefore, advanced age led to home deliveries due to the negative/inquisitive attitude of medical staffs who were abusive, generally harsh and harassed the women.

Young unmarried pregnant women were not spared either. Claims by these respondents interviewed were that young unmarried pregnant women delivered at home to avoid quarrels from medical staff for not attending ANC. They argued that medical staff were irate because these young women were only rushed the last minute to give birth in a health facility and therefore the women chose to give birth at home to be at peace.

Other claims by the respondents were that these young pregnant women, on account of their tender age were despised and harassed in labour ward if they did not comply with instructions given by the nurse and sometimes they were beaten. In contrast to this treatment, the respondents claimed that no TBA beat her client; instead the TBA showed absolute mercy and kindness to the woman giving birth.

These sentiments by the respondents about insults by nurses are echoed in a report by FIDA of 2010 that documented how pregnant women were maltreated when they sought maternal health care services in public health facilities (FIDA Report, 2010). Some respondents maintained that age did not influence where a pregnant woman chose to give birth, but did not give any reasons to support their claims. It is common knowledge that pregnant women should know the importance of giving birth in a health facility irrespective of age and take full advantage of this chance to avoid problems that could occur during childbirth. Thus from the discussion above it is clear that age was an influencing factor in choosing place of delivery for pregnant women in their tender age and aged pregnant women.

This conclusion was in line with the findings of Banda (2013) who carried out a research in Ntchisi District in Malawi focusing on, 'Barriers to Utilization of Focused Antenatal Care among Pregnant Women'. Similarly, the Chi-square test analysis ( $\chi^2=4.356$ ;  $df=2$ ;  $p = 0.045$  where  $p \leq 0.05$  cf. appendix 7 p174), showed that the older the pregnant woman the greater the likelihood of giving birth at home. The results of the above Chi-square are confirmed by Gabrysch and Campbell (2009) who established that the higher the maternal age, the less likely for the pregnant woman to deliver in a health facility. As well, Grunebaum (2013), points out that, women between the ages of 35 and 49 were less likely to seek skilled delivery services especially if they had delivered other children without a problem as compared to women who were younger.

### **7.2.5 Cultural Beliefs and Practice**

The study found that cultural beliefs and practice concerning childbirth such as rituals associated with the placenta did not influence where a woman would deliver her baby. Even if such beliefs existed in their families, this did not influence their choice of place of delivery. Although in some cases cultural beliefs and practice regarding childbirth existed, they were purely to ensure there was harmony. Therefore it can be contented that to a large extent cultural beliefs and practice were less likely to influence a pregnant woman's choice of where to give birth. The Chi-square analysis confirmed this finding in that there was no relationship between cultural beliefs and where a woman would deliver ( $\chi^2=1.285$ ;  $df=2$ ;  $p=0.526$ , where  $p \leq 0.05$  cf. appendix 7 p174). This relationship disagrees with a study carried out by Nuraini and Parker (2011) in Xien Khouang Province, Indonesia which indicated that culture was significantly linked with utilization of ANC services.

### **7.2.6 Permission from Significant Others**

The study found that some pregnant women sought permission to plan where to deliver. Some respondents however did not seek permission due to the realization that in case of any problems, they were the ones to suffer in the end. Therefore they did not see the need to seek for permission from anyone. The study found that the respondents sought permission from their husbands because they provided financial support and were the head of household and could step in, in case of emergencies and also to avoid discord in the family. Others sought permission where to deliver from their mothers especially those who were unmarried. This category of pregnant women chose to get permission from their mothers because they were more experienced in childbirth. Other respondents sought permission from their mothers-in-law because they were more experienced in childbirth and to sustain familial cordial relationship. Grandmothers were also consulted as per this study because they were

the ones who were available in the family during childbirth preparation period. The respondents said they delivered at home because of the encouragement by their significant others who included; a father of one of the unmarried respondents, a mother-in-law and family members of one of the respondents. The father of the unmarried respondent did not explain to her why she had to give birth at home. One of the respondents among this group contended that her mother-in-law was a good TBA and therefore there was no need to look for another option. Some respondents said they gave birth at home because, *“To give birth at home is less expensive because the question of transport and buying new clothes for the baby was costly”*. However some respondents did not give reasons for delivering their children at home. The views of these respondents are supported by Owino and Legault (2013) who point out that place of delivering the baby for married women was chosen by their husbands while the place for unmarried women was chosen by their mothers.

Owino and Legault (2013), in support of the assertions by the respondents, posited that utilization of maternal health care services for pregnant women depended on significant others especially husbands and mothers if the pregnant woman was unmarried. Leone (2016) on the other hand conducted a research in Sunamganj, Bangladesh in 2015 and established that husbands made 50 percent of the decisions at family level regarding maternal and healthcare utilization. Magoma et al., (2010) in their research came up with similar views regarding influence of husbands on choice of place of delivery for their wives. Their research which was conducted in Ngorongoro, Arusha, Northern Tanzania in 2008, revealed that husbands usually made sure that they chose place of delivery for their wives among the Maasai and Watemi communities. As observed in the above discussion regarding where respondents finally delivered their babies, it was notable the majority of non-ANC-attendees delivered at home under the influence of significant others.

Magoma et al., (2010) point out that in some African communities, childbirth are events embedded with social meaning and often involve significant family members and community participation. Contributing to the role played by significant others in influencing place of delivery, Mpembeni et al, (2007) point out that, women who reported that they ever discussed with their husbands or partners on where to deliver while pregnant, had a higher chance of delivering in a health facility. Further, the findings of this study collaborated with the findings of Kitonga (2011), who asserted that some of the reasons to non-access to delivery of health care services in India, were due to the fact that the women had to seek permission from their husbands or mothers-in-law. In addition, a study carried out by Agus and Horiuchi (2012) in West Sumatra, Indonesia focusing on factors influencing the use of antenatal care services revealed that pregnant women were largely encouraged by their family to seek ANC services and these women had to comply.

When decisions regarding place of delivery were made on behalf of a pregnant woman, she was deprived of her ontological autonomy in decision making. What was observable in the above discussion was clearly linked to Empowerment Autonomy Theory by Anderson and Christman (2013). This theory hypothesizes that, to make an informed decision, an individual should be self-directing based on informed decision and values related to the subject matter at hand. On the same note, Albritton (1985) maintains that an individual's point of view is directed by her highest desires which propel her to act. These views of Anderson and Christman (2013) and Albritton (1985) were relevant in this case because for pregnant women to choose where to deliver their babies, they were expected to exercise some form of self-direction or to be autonomous in making this decision.

Effects of autonomy on choice of place of delivery was further demonstrated by Magoma et al., (2010) who found out that women who lacked autonomy in choosing place of delivery experienced challenges in accessing maternal health care services because their

decisions were perpetually interfered with by others. Although Magoma et al., (2010) and Fotso et al., (2009), viewed women's autonomy in health seeking behaviours as insignificant, this research revealed that some pregnant women enjoyed the freedom to choose where to deliver their babies. In fact, women's autonomy in decision making is pivotal in choosing the use of maternal and child health care services (Woldemicael, 2007). Though according the study some respondents were able to make decisions concerning where they would deliver the baby, it was evident that they still needed affirmation from their spouses or parents if they were not married on what they had decided.

### **7.2.7 Determinants of Final Choice of Childbirth**

**Perceived Complication Risk:** When a person recognizes that a health condition is personally affecting the individual, such a person will take the necessary safety measures. In this connection, the study found that pregnant women chose to deliver in a health facility because of their prior complications during childbirth. Some respondents delivered in a health facility as a precautionary measure in case of excessive bleeding after delivery. Such respondents hoped that in case of any complication associated with the new born; the medical staff would deal with the situation. Their choice was influenced because of their experiences during childbirth. This explains why they sought to deliver in a health facility where there was professional help.

In some instances, the respondents said that they were transferred to a health facility when it became obvious to the TBAs assisting them that it was impossible to deliver at home. It was clear from the above responses that so long as a pregnant woman had not experienced prior complications during childbirth; she was likely to decide to give birth at home. These findings had similar views as those echoed by Anyait and Mukanga (2012) who point out that previous complication in childbirth were a predictor in determining a health facility delivery.

These views of Anyait and Mukanga (2012) are also in line with what Andersen (1995) postulates regarding utilization of health care services. Andersen (1995) observes that for an individual to access health care services, an element of experience of the condition should be present. In the context of this study, it meant that women who suffered prior complications during childbirth saw the need to give birth in a health facility.

This study found that many pregnant women had intended to give birth at home especially for those who did not attend ANC. Another remarkable feature observed was that even if these women were attending ANC, they had not identified the specific health facility where to give birth. Some of them were not even sure where to give birth. Judging from this observable trend, it could rightly be interpreted that these respondents who had not yet chosen where to deliver their babies, would most likely prefer to give birth at home.

The decision made by respondents to deliver in a health facility is backed by Yifru et al., (2014) who advise that women with prior history of complications should deliver in a health facility where trained obstetricians would give professional help. On the same note, Gabrysch and Campbell (2009) who were exploring determinants of health care services confirmed that women with previous obstetric complications, preferred to deliver in health care facilities. The perspectives of the respondents about their choice of place of delivery as a result of their experiences of childbirth complications corresponded with what Gabrysch and Campbell (2009) found out. From their search of articles from Pub-Med, Ovid databases and other relevant sources for reviews to ascertain determinants of delivery service use, Gabrysch and Campbell (2009) established that previous obstetric complications increased use of health facility. On the same note, Anyait and Mukanga (2012) who carried out a research in Busia district of Uganda to determine predictors for health facility delivery came to the same conclusion that, pregnant women with previous difficult deliveries sought health facility delivery. Notwithstanding what has been said by Gabrysch and Campbell (2009), Yifru et al.,



(2014) Anyait and Mukanga (2012), regarding choice of place of delivery for pregnant women with prior childbirth complications, the HBM by Becker and Maimam (1977) outlines pertinent suggestions in support of pregnant women's choice to deliver in a health facility as discussed below.

**Perceived Severity:** This has to do with psychological, physical and social implications of home delivery. For instance, the respondents who underwent caesarean section knew well enough the danger of home delivery where the scar could rupture. For those who had lost babies knew the traumatic experience and were likely to be fearful going through the same experience again. The same thing would apply to the respondents who had given birth to premature babies. They were likely to detest a recurrence of the same experience.

**Perceived Benefits:** The assumption here is that the respondents must have anticipated certain benefits which were feasible. This in turn gave them the inspiration to choose to deliver in a health facility. One likely benefit according to these respondents would be professional health personnel that would deal with complications in case they happened to be there. Generally when respondents were asked to explain what could be the consequences of the complications they mentioned, they seemed not to know. Based on this level of understanding one could conclude that the respondents were not likely to perceive the severity of the conditions they mentioned. The lack of how severe a health problem could be was likely to interfere with the respondents' choice of place of delivering their babies. Lack of knowledge of awareness of complications that could occur during childbirth and particularly the consequences thereof, could not be a precursor to influencing a pregnant woman's choice of place of delivery. Besides, some of the information the respondents knew pertaining to problems that could affect the fetus and after birth was faulty. According to Bailey (1974), the fetus gets oxygen and nutrients through the placenta via umbilical cord not from the amniotic fluids, as claimed by one of the respondents. On the other hand, yellow

fever is caused by an aedes mosquito and cannot be transferred from the mother to the fetus (Ministry of Medical Services, 2009), as also alleged by another respondent.

Therefore the findings in respect of awareness of complications affecting the baby and the mother were not in agreement with those of Mpembeni et al., (2007) who posited that there was significant association between awareness of knowledge of maternal and baby complications with usage of mother and child health care services. The findings were as a result of a study Mpembeni et al, (2007) carried out in Southern Tanzania where they explored, “Use pattern of maternal health services and determinants of skilled care during delivery”. In this connection, a joint report by WHO and UNICEF of 2003 on antenatal care in developing countries and missed opportunities between 1990 and 2001, came to the conclusion that good care of the woman during pregnancy and childbirth was associated with reduced rates of deaths of mother and infant. It can therefore be rightly construed that the respondents who chose to deliver in a health did so to benefit from medical staff professionalism. These respondents were likely to have been motivated to choose to deliver in a health by the reasons cited by WHO and UNICEF (2003).

The views of these respondents regarding their planned choice of place of delivery are supported by Yifru et al., (2014) who observed that there was a strong association between antenatal care and health facility delivery. The objective of Yifru et al., (2014) in their study, was to assess the connection between antenatal care services with birth in a health facility. These authors further affirmed from their analysis that the increase in health facility delivery among pregnant women attending antenatal care clinic was probably because the women were already aware of its advantage. Yifru et al., (2014) further contend that, these antenatal women might have been well familiar with the health facility environment and the health care providers where they have been attending their ANC.

**Perceived Barriers:** This is about one's unconditional efforts to overcome all barriers in order to get the desired services. In this study, the major barrier that affected the timely delivery in a health facility was the influence by significant others. The study viewed these experiences as a precursor to determining if childbirth experiences influenced choice of place of delivery of respondents.

Under infrastructure, the researcher explored if availability of transport and road networks affected pregnant women's choice of place where they would deliver their babies. Therefore their preference of place of delivering their babies was not influenced by means of transport. However one percent of the respondents pointed out that they were far away from the health facilities which offered maternity services for 24 hours. The nearby health facility for one of them was Kwamulungu which operated from 8 am and closed at 5 pm. Therefore if labour pains began at night, relatives had to look for transport which was expensive because no public vehicles commuted within their neighborhood. To confirm this point, one of the respondents said, *"I had planned to deliver my second born in a health facility but I ended up giving birth at home because I did not have enough money to hire a vehicle to take me to Kauwi health facility which operates for 24 hours. From my home to the health facility was Ksh 3000 one way"*.

From the above discussion it was observable that transport did not significantly affect the choice of place of where babies would be born for the majority of the pregnant women. Respondents maintained that means of communication to access health facilities was not a problem because transport was available. Nonetheless, 10 percent of the ANC-attendees affirmed that means of transport could affect their choice of place of delivery. These respondents indicated that they lived a bit far from the health facilities and road networks were poor. For the respondents to access a health facility, they had to hire private transport which was expensive. Nevertheless, the Chi-square test analysis in this connection attested

that there was no statistical significance between availability of means of transport and preference of place of delivery ( $\chi^2=0.198$ ;  $df=2$ ;  $p =0.906$  where  $p\leq 0.05$  cf. appendix 7 p174). The researcher expected similar results because Kitui West Sub-county has good road networks and means of transport was available. Besides, the health facilities were accessible because they were within a radius of 4-5 Kms according to the DPHN. The results in both cases for ANC-attendees and non-ANC attendees, were not commensurate with those of Agus and Horiuchi (2012) who established that means of transport to the health facility was significantly related to access to maternal health care services. These authors researched on, “Factors influencing the use of antenatal care in rural West Sumatra, Indonesia”.

Out of 135 ANC-attendees, 45.2 percent were aware of the some complications that could occur to a baby during childbirth, surprisingly 26 percent of them delivered previous children totaling to 60 at home despite the fact that they were ANC-attendees. The Chi-square tests analysis ( $\chi^2=4.953$ ;  $df =2$ ;  $p=0.084$  where  $p\leq 0.05$ , cf. appendix 7 p174) confirmed that awareness of complications related to a baby during childbirth was insignificant. Among the ANC-attendees, 66 percent of them were aware of some complications pertaining to a woman during childbirth. Despite this knowledge, 37 percent delivered their previous children at home. Therefore it can be construed that knowledge of awareness of likely complications during birth did not influence choice of place of delivery as confirmed by the Chi-square test analysis ( $\chi^2=0.230$ ;  $df =2$ ;  $p=0.891$  where  $p\leq 0.05$ , cf. appendix 7 p174). A similar trend of awareness of knowledge of complications pertaining to a pregnant woman during childbirth was observed regarding the 30 non-ANC-attendees. The Chi-square test analysis; ( $\chi^2=4.352$ ;  $df =2$ ;  $p=0.113$  where  $p\leq 0.05$ , cf. appendix 8 p175) indicated that there was no significant association between awareness of knowledge of maternal complications during childbirth and choice of place of delivery. Likewise, knowledge of complications that could occur to a baby seemed not to influence the non-

ANC-attendees in their choice of place of delivery as confirmed by Chi-square test analysis ( $\chi^2=0.599$ ,  $df =2$ ;  $p=0.741$  where  $p\leq 0.05$ , cf. appendix 8 p175). The findings as regards to knowledge of awareness of problems affecting the baby and the mother were not in agreement with those of Mpembeni et al., (2007) who posited that, there was significant association between knowledge of awareness of maternal and baby complications with usage of mother and child health care services.

The hospital, as suggested by Jones (2013) was the safest environment for the mother at risk because of medical complications. This being the case, Kumbani et al, (2013) maintain that it was critical for pregnant women to deliver in a health facility. Kumbani et al, (2013) stress that pregnant women should be encouraged to deliver in a health facility to reduce MMRs and IMRs. Their views also concurred with those of Cruz and Adams (1976) who argue that pregnant women should be aware of complications that may arise during childbirth so that appropriate measures could be taken to save the life of mother and infant. Interestingly, according to this study, pregnant women seemed not to be influenced by the useful tidings by these authors.

Precipitated labour is a condition that might not allow normal preparation for childbirth to take its natural course. This study found that fast progression of labour was a determinant of choice of place of delivery and is supported by Cotter et al., (2006) who point out that quick labour may result to a pregnant woman not being able to seek delivery services in a health facility because of time factor. Faced with such scenario, it can be said that precipitated labour to a large extent determined the options for delivery. Besides precipitated labour, difficult labour is one of the underlying causes of maternal and infant deaths around the world (Magadi, 2000b). It is estimated that 488 maternal deaths per 100,000 live births occur in Kenya according to KNBS & ICF Macro, (2015). These deaths are associated with prolonged and difficult labour among other causes. That is why Yifru et al., (2014) suggest

that women with a history of previous caesarean section or prolonged labour should be referred for hospital delivery. The TBAs who referred their clients to a health facility in this study as a result of prolonged labour saved their lives. Some of these women underwent caesarean section because they could not deliver normally.

Ruptured membrane was another complication that made respondents seek medical help. Irregular labour pains were yet another factor that led to some of the respondents to deliver in a health facility. One of the respondents in this category noticed poor progression of labour in the process of childbirth. She experienced weak irregular labour pains because of poor uterine contractions and could not deliver at home. However, she eventually delivered in a health facility. Cruz (1976) associates uterine action with psychological needs of the pregnant woman. Irrational fear that the child may be malformed, fear that labour will not progress well would certainly cause tension hence disturb normal rhythm of the uterine action. Such unfounded fear can be dealt with in an ANC where the pregnant woman should be given an opportunity to bring out her fears and worries as opposed to asking routine questions such as how they were feeling (ibid).

Another complication observed was pelvis structure which made some of the respondents to deliver in a health facility. One of the respondents intended to deliver her baby at home but the TBA advised her to seek medical help because her pelvis structure was too small to allow normal delivery. The view of the TBA in this case is backed by Magadi (2000b) who points out that some pregnant women of certain height may not be able to deliver normally because their pelvis may not accommodate the baby during delivery and they may experience obstructed labour. Apart from experiencing obstructed labour, a pregnant woman with small pelvis stands a high risk of having a low-birth weight baby or undergoing caesarean section (Brandon et al., 1992).

Drawing from this discussion, it can be concluded that women with small pelvis structure should be encouraged to attend ANC and deliver their babies in a health facility to scale down the anxieties they may harbor at the time of childbirth.

### **7.3 Opinions of Informants on Choice of Place of Delivery**

In this study, informants referred to nurses and TBAs. These respondents indicated that it was advantageous to deliver in a health facility in case of excessive bleeding, difficulty labour, and the baby failing to cry immediately after birth, premature delivery, and avoidance of HIV transmission. Other respondents said a pregnant woman benefited from medical professionalism. This was advantageous because nurses dealt with the situation urgently.

The knowledge TBA had was passed to the pregnant women and it was significant in informing delivery of babies at home because the respondents had confidence in them. After the TBA's assurance of normal possible delivery at home the pregnant women were confident that all would be well. For instance, one of the pregnant women had previously lost a baby during delivery at home and interestingly, she still sought the services of a TBA claiming that death could happen anywhere because it was God's design. Another respondent defied the advice of the nurse against delivering at home because the TBA had confirmed to her that the position of the baby in the uterus was okay and normal delivery was feasible. One more respondent with ruptured membranes and the amniotic fluid having drained out and bleeding started, she still believed the TBA and her mother-in-law would manage the situation and they indeed managed.

The centrality of a TBA especially among the rural communities is associated with the highly valued social role they played in the communities (Owino and Legault 2013). The TBAs offered emotional support and continuity of care in comparison to the type of care that is made available at the health units. For instance, TBAs in Maasai usually go together with

pregnant women to antenatal clinics, examine them at home, and refer them to health units for care if they identified a potential problem, otherwise during normal delivery TBAs stay with women giving birth through labour and up to five days after delivery (Magoma et al., 2012). On the other hand, TBAs satisfy the expectations of the pregnant women which include; continual support and advice during pregnancy, delivery, and after delivery, the provision of body massage throughout labour and delivery, and knowledge of a variety of delivery positions (Magoma et al., 2012). All these good tidings by the TBAs build a strong faith and confidence among the pregnant women who receive their services. Contributing to this discussion on confidence in the TBAs, Rahmani and Brekke (2013) maintain that TBAs were popular because they were not expensive as they were paid in kind; they were tolerant and kind, and spent more quality time with pregnant women. Rahmani and Brekke (2013) added a pertinent point when they pointed out that some of the women they interviewed did not have confidence in the new village midwives because the latter were often young, unmarried, and inexperienced. Interestingly, Agus and Horiuchi (2012) conceded that TBAs displayed overt interpersonal skill, special care, and respect for local customs which could not be exemplified by village midwives who were viewed as too young and inexperienced. In this connection, TBAs were viewed as more mature, patient and caring compared with these midwives.

In Butajira district of Ethiopia, women preferred to deliver at home assisted by TBAs because members of the family were allowed to be with the expectant women during labour and delivery which was consoling (Roro and Hassen, 2014). Ten percent of the respondents out of 135 interviewed in this study had similar views with Roro and Hassen. For instance, one of the respondents aged 38 interviewed in this study said, *“I am too old to be assisted by a young midwife in a health facility”*. While another said, *“I feel safe to be assisted by a TBA”*. *“So long as the position of the baby in the uterus was okay, delivering at home where*



*the environment was conducive was preferred to a health facility,”* one respondent asserted. *“Hospitals are for referrals and it was okay to deliver at home,”* said one other respondent. However, these assertions expressed by these respondents were based on their previous safe deliveries. In this regard, the central role of a TBA in influencing the choice of place of delivery could not be overlooked as observed by the respondents during FGDs. During the FGDs, the participants indicated that hospitals became the last resort when complications set in during childbirth at home. It was also observed from the discussion that choice of place of delivery was also based on past experiences if the previous deliveries were normal or had complications.

According to the TBAs, when the head of the baby was presenting, normal delivery was envisaged and therefore the women chose to deliver at home. The TBAs also identified age as another determinant of choice of place of delivery. In support of their claims regarding age as a determinant of place of delivery, the TBAs asserted that, young pregnant unmarried women were afraid of stigma from peers hence they preferred to give birth at home. Likewise pregnant women advanced in age were afraid of undergoing caesarean section and therefore they avoided giving birth in a health facility.

Based on these assertions by the TBAs about what pregnant women say about delivering their babies in a health facility, can influence their choice of place of delivery. Of particular interest is the negative attitude of nurses’ towards pregnant women. The negative attitude of nurses towards pregnant women was also noted by Kumbani et al., (2013) in their research in Southern region of Malawi, in the Chiradzulu district.

The study explored why some women failed to give birth in health facilities. Accordingly, one of the reasons why women did not deliver their babies in a health facility in Chiradzulu district of Malawi, was the unfriendly attitude of nurses towards pregnant women.

The TBAs clearly stated from the above discussion that women who had previous safe deliveries either at home or in a health facility were likely to choose to deliver their babies at home. In their discussion, they indicated that such women did not perceive any childbirth problems that could happen during the time of delivering their babies. They viewed all pregnancies to be the same. It also came out during the discussion that women who had previous safe deliveries were likely to influence their daughters and daughters in law to give birth at home.

The study found that nurses were of the view that pregnant women who were married and had support from their family members were likely to choose to deliver in a health facility. The nurses further pointed out that; pregnant women who had experienced prior complications during childbirth chose to deliver in a health facility. They also affirmed that enlightened parents of young unmarried pregnant women were likely to encourage their daughters to deliver their babies in a health facility. Some of these respondents observed that, pregnant girls who had dropped out of school and without money delivered at home. The respondents further pointed out that, women who were aware of the advantages of delivering in a health facility were likely to access health delivery services. All the respondents indicated that, the attitude of some nurses deterred some women from choosing to deliver in a health facility. The discouraged women in this case opted to deliver at home.

This study observed that there existed mutual collaboration between nurses and TBAs. The majority of the TBAs had connection with the nurses which according to the researcher was a good sign regarding collaboration. When TBAs interacted with nurses about safe motherhood, the former were likely to improve their performance in conducting deliveries.

## **8.0 CHAPTER EIGHT: SUMMARY, CONCLUSION AND RECOMMENDATIONS**

### **8.1 Introduction**

This chapter discusses the summary of the major findings from which conclusions are drawn and recommendations adduced. Part of the recommendations suggests a policy brief and areas of further research.

### **8.2 Summary of Findings**

This study sought to answer 3 research objectives; to explore from pregnant women their choice of place of delivery in Kitui West Sub-county and reasons for their choice, to determine where the pregnant women finally delivered their babies and what influenced their choice in Kitui West Sub-county, to increase knowledge about pregnant women's choice of place of delivery from the views of informants who included TBAs and nurses in Kitui West Sub-county. The study found that the major factors informing the choice of place of childbirth in Kitui West Sub-county included; complications during delivery; age of the pregnant woman; previous childbirth complications, influence by significant others, previous safe deliveries and confidence in the TBA.

The study found that major reasons for choosing to give birth in a health included; occurrence of complications which could affect the woman during childbirth. The mentioned possible complications were; excessive bleeding after delivery in case of retained placenta which could possibly lead to death; prolonged labour, transmission of HIV, breech presentation and high blood pressure during childbirth .To make pregnant women become aware of the complications that may arise and care of themselves and their children, the study found that nurses were crucial because they served as advisors to the pregnant women. The nurses disseminated knowledge to the pregnant women who attended ANC on how to bathe

newborns, application of eye ointment immediately after birth, best breast feeding methods, nutrition, hygiene and safety during delivery. Other information included; immunizing the newborn, handling of premature babies and scrutiny of the newborn to ensure that there was no problem or deformity. Interestingly, the study found that some complications like excessive bleeding and prolonged labour were believed to be caused by witchcraft.

The study also found that, in the absence of complications, young unmarried pregnant women in their first pregnancy were reluctant to deliver in a health facility. This was attributed to the fear of rigors of childbirth even though they did not have experience in childbirth. The Chi-square showed that giving birth at home depended on the previous safe deliveries as shown in Chi-square test analysis, ( $\chi^2=1.701$ ;  $df=4$ ;  $p=0.044$  where  $p \leq 0.05$  cf. appendix 7 p174). The Chi-squares indicates that previous safe deliveries were significantly associated with choice of place of delivering the baby. Therefore perceived vulnerability as evidenced in previous deliveries had a great impact on the choice of eventual place of delivery such that the more vulnerable a woman was the more likely was health delivery planned.

Concerning influence of income on choice of place of delivery, the study found that it did not influence. However exorbitant transport cost could influence a pregnant woman to give birth at home. Nevertheless, the Chi-square test analysis ( $\chi^2=14.012$ ;  $df=14$ ;  $p=0.449$  where  $p \leq 0.05$  cf. appendix 7 p174); confirmed that there was no relationship between the level of income and the choice of place of delivery.

The age of the pregnant women was found to influence where they delivered their babies. For instance the study found that pregnant women with advanced age felt uneasy in a maternal health care clinic. These women feared to be disgraced by women colleagues and medical staff and they therefore preferred to give birth at home. Therefore, advanced age led to home deliveries due to the negative/inquisitive attitude of medical staffs who were abusive

and generally harsh. As well, young unmarried pregnant women were not spared of the impact of the negative attitude of medical staff. However, the study found that TBAs were reasonable when dealing with pregnant women of all ages hence promoting home deliveries. The Chi-square test analysis ( $\chi^2=4.356$ ;  $df=2$ ;  $p = 0.045$  where  $p \leq 0.05$  cf. appendix 7 p174), showed that the older the pregnant woman the greater the likelihood of giving birth at home.

On cultural beliefs and practice concerning childbirth, the study found that there was no influence on where a woman would deliver her baby. However such beliefs if they existed were purely for familial harmony. The Chi-square analysis confirmed this finding in that there was no relationship between cultural beliefs and where a woman would deliver ( $\chi^2=1.285$ ;  $df=2$ ;  $p = 0.526$ , where  $p \leq 0.05$  cf. appendix 7 p174).

The study found that significant others had to give permission to allow a health facility delivery. The study found that the respondents sought permission from their husbands because they provided financial support and were head of the households. Others sought permission from their mothers and fathers especially those who were unmarried in order to be supported financially. Others sought permission from their mothers-in-law because they were more experienced in childbirth and also to sustain familial cordial relationship. Grandmothers were also consulted as per this study because of their availability in the family during child birth preparation period. It is important to note that the significant others were handy in encouraging pregnant mothers to either deliver in a health facility or at home.

On the second research question, the study was able to highlight the determinants of the final place of choice of childbirth. Therefore the study found perceived susceptibility, perceived severity, perceived benefits and perceived barriers were significant in determining where the pregnant woman delivered. Perceived susceptibility has to do with the recognition that if a health condition is personally affecting an individual; such a person will take the necessary safety measures. Thus, the study found that pregnant women chose to deliver in a

health facility because of their prior complications during childbirth; their choice was influenced by the recognition that in health facilities, professional help was at hand. It should be noted that there was a direct relationship between attendance of ANC and ascertaining susceptibility.

For perceived severity it is contended in this study that, it has to do with psychological, physical and social implications of home delivery. This was directly linked to previous experience of childbirth such that if the pregnant women experienced complications during home delivery, then the following deliveries would most likely be done at a health facility. Another finding of this study has to do with perceived benefits of place of delivery. This in turn gave them the inspiration to choose to deliver in a health facility. One likely benefit according to the study was professional health personnel that would deal with complications in case they occurred. However the study found that some of the information the respondents knew pertaining to problems that could affect the fetus while in the uterus and after birth was faulty.

The study further found that perceived barriers were significant in determining the eventual place of delivery. The study found that it was important for the pregnant women's ability to unconditionally strive to overcome all barriers in order to get the desired services. In this study, the major barrier that affected the timely delivery in a health facility was the influence by significant others. On the other hand, the study found out that means of transport did not influence choice of delivery for pregnant women. The Chi-square test analysis in this connection attested that there was no statistical significance between availability of means of transport and preference of place of delivery ( $\chi^2=0.198$ ;  $df=2$ ;  $p=0.906$  cf. appendix 7 p174 where  $p \leq 0.05$ ). This was so because, in Kitui west Sub-county, the health facilities were accessible because they were within a radius of 4-5 Kms.

Finally the third question the study tackled was the views by nurses and TBAs regarding women's choice of place of delivery. According to these respondents, women chose to deliver in a health facility in case of; excessive bleeding, difficult labour, baby failing to cry immediately after birth, premature delivery and avoidance of HIV transmission. Although, according to the nurses and TBAs, pregnant women were given health talk during ANC, interestingly, this knowledge of awareness of advantages of delivering in a health facility was insignificant (6 percent) in influencing final place of delivery.

An interesting finding of this study was that the TBAs offered emotional support and continuity of care in comparison to the type of care that is made available at the health units. The TBAs were found to satisfy the expectations of the pregnant women. However, the study found that some pregnant women did not have confidence in the new young midwives in the health facilities because they were often young, unmarried and inexperienced unlike the TBAs who were more mature, patient and caring.

The study found that nurses were castigated because of the attitude of some of them which deterred some women from choosing to deliver in a health facility. The discouraged women in this case opted to deliver at home.

### **8.3 Conclusion**

Chapter seven which was a discussion chapter established that level of education, occupation; religion and cultural beliefs and practice and access to health facility were not determinants of place of delivery. It was also noted that marital status had a weak relationship regarding place of delivery. A significant number of the respondents who chose to deliver in a health facility did so in case there arose complications during childbirth. The respondents were also influenced to deliver in a health facility because of the care and professionalism of the nurses.

Significant others played a part in encouraging respondents to deliver in a health facility.

Respondents with previous childbirth complications opted to deliver in a health facility. A significant number of respondents were of the opinion that age influenced choice of place of delivery.

Some respondents delivered at home because their previous deliveries at home were without complications. These respondents were also assured by TBAs that delivery at home was possible. The role played by significant others was remarkable in influencing respondents to give birth at home. Knowledge of awareness of possible complications did not influence respondents to chose to deliver in a health facility because some of the respondents who indicated that they were aware of some complications delivered at home. While majority of the respondents indicated that level of income of a pregnant woman was not a determinant in choosing place of delivery. The discussion also indicated that a significant number of the married respondents sought permission from their husbands before choosing place of delivery.

#### **8.4 Policy Implications**

In reference to the interview with TBAs and nurses it was noted that there was a government policy which discouraged TBAs from conducting deliveries at home except in emergency cases. According to the DPHN, this government policy came into being through WHO. The policy stipulated that all pregnant women should be delivered by a skilled person (medical professional) in order to reduce maternal and neonatal deaths. Accordingly, the nurses were well aware of this policy.



According to this policy, a TBA should refer a pregnant woman to a health facility because the former may not recognize problems of childbirth in time. According to the policy, it was feared that a TBA could perform dangerous procedures detrimental to the pregnant woman and the fetus such as manual positioning of the fetus.

Despite this policy, a significant number of women continued to deliver at home assisted by TBAs. Evidently, this study revealed that 90 percent of the respondents out of 30 non-ANC-attendees, delivered at home assisted by TBAs while 36 percent of 135 ANC-attendees also delivered at home assisted by TBAs. The findings of this study revealed that a TBA still remained relevant to the community especially during childbirth. Additionally, a TBA has multiple other roles such as healing, counseling, determining where the pregnant woman would deliver her baby. She had the ability to develop cordial relationship with pregnant women they served and mediated between the pregnant women and their husbands when the latter were reluctant to take their wives to deliver in a health facility. Having ascertained the insightful role of the TBA, it would seem unwise to abandon the maternal services of a TBA since there is good evidence from this research supporting their vital role among community members.

## **8.5 Recommendations**

- Based on the confidence this community had in TBAs as revealed by the study, there is therefore the need for MoH to train the latter in basic skills in order to give standardized maternal health care services. This was deemed necessary because according to the study, 5 babies died during childbirth in the patronage of TBAs as indicated by non-ANC-attendees during interview in Phase I regarding previous history of childbirth. During interview with the TBAs, it was also revealed that 3 babies and a mother died during childbirth while being assisted by TBAs. It is hoped

that by TBAs acquiring basic skills in maternal health care, neonatal deaths could be scaled down.

- The study established that there was collaboration between the nurses and the TBAs and both were striving towards one goal of safe deliveries. Given that the TBAs and the nurses focused on safeguarding mother and child during childbirth, this link could be enhanced by training TBAs and allowing them to conduct deliveries alongside nurses to learn new skills that they probably did not have. Nurses could make follow ups to accompany the TBAs as they perfect their skill in their respective communities. This kind of collaboration between the nurse and the TBA is hoped to increase health facility deliveries.
- During interview with TBAs, it was revealed that TBAs in some cases used their own resources to facilitate pregnant women to access maternity services. The researcher cannot fail to ask, why the pregnant woman and her husband were not prepared for such emergencies. Does it mean they never thought about it or were they passive about such issues? Again, could this be negligence or cultural misgivings-meaning that, the husband who is assumed by the culture to take such responsibilities has failed or on the other hand he is being forced to territories he feels inadequate to prepare for.
- In the same context, why should the TBAs use their own resources while the pregnant woman and her husband had 9 months to prepare. Is it poverty or what? This situation could be avoided if possible measures were put in place during pregnancy. However a further research could be carried out to explore these aspects.

- An aspect that could empower pregnant women in gaining autonomy in deciding where to deliver their babies would be the awareness of their reproductive rights. This claim was based on the findings of the study whereby the 5 nurses indicated that majority of pregnant women were not aware of their reproductive rights. According to one of the nurses, some pregnant women who were to undergo caesarean section, insisted that their spouses must sign to authorize the operation even in cases of emergency. During the interview, the DPHN indicated that, the nurses were usually few and quite busy with other responsibilities making it impossible for them to teach about reproductive rights. Therefore, she recommended that other agencies to take up this responsibility.
  
- TBAs could be taught reproductive rights of pregnant women by MoH with a view of disseminating the same information to pregnant women whom they accompany. In this way, pregnant women could be empowered to take active role in decision making concerning maternal health care. Tshabalala (2013) observes that knowledge is power and enables decision-making. This could mean therefore pregnant women who were not aware of their reproductive rights, their decisions regarding their reproductive health could be influenced. According to Rahaman (2013), women's empowerment is a total change of how things are done in terms of institutions responsible for women's inferior position in the society. Therefore, women's empowerment entails gaining; control over their lives, being involved in making decisions that affect their lives in their homes and in the community, in government, and in global development strategies and creating new opportunities (ibid).

- The study has also recognized that there are other challenges that hinder women from delivering with a TBA or at the health facility. Some of these challenges are broad and they extend to cultural beliefs and practice. In fact the TBA could be facilitated by the MoH to be a link between some of these limiting cultural practice and influence pregnant women to prefer health seeking behavior.
- As well, CHVs who are recognized by the community members could also be used to increase awareness of advantages of health facility delivery. This would be an advantage especially for pregnant women who do not attend ANC. The study revealed that 67 percent of non-ANC-attendees were not aware of advantages of delivering in a health facility.
- In order to increase health facility deliveries, women within childbearing age and significant others could be empowered with knowledge related to pregnancy and childbirth by MoH. This awareness would be key since the study revealed that; 34 percent of ANC-attendees were not aware of problems that could occur to a pregnant woman during childbirth.
- Communication during health talk and any handouts could be in a language that is readily understood by the recipients (pregnant women). A case in point is the booklet, ‘Mother and Child Health Handbook: Afya ya Mama na Mtoto’ (MOH, 2016) supplied by MoH to pregnant women which is written in English. The booklet contains some medical jargons such as conversion or pale, which may not be understood by the majority of the pregnant women. Based on the study observations, it was established that when the pregnant women were asked by the researcher during interviews to mention some problems that could occur to a pregnant woman during

childbirth, they were not in a position to do so despite having the booklet. While this lack of knowledge could imply many reasons such as not being able to read and understand the language in the booklet, still communication should be readily understood by the recipients.

This study has emphasized the need to translate the booklet into local language of the respondents. Also, it would be important for the health providers to check with the pregnant women whether the information in the booklet has been useful.

- Based on the number of women who were encouraged by significant others to deliver at home, the study recommends another research to find out if the knowledge of significant others regarding possible complications that could occur during childbirth was deep enough to encourage women to choose to deliver in a health facility.
- In reference to the study findings, pregnant women who had attained higher education were expected to make better judgments about place of delivery. According to this study, both women who attained higher education and those with lower education delivered at home or in a health facility indiscriminately. Therefore, there was no difference between these 2 categories. Based on these observations, the study recommends further research to analyze why education attained did not influence place of delivery. The same research could also investigate why a document policy by Murunga (2015) aimed at incorporating adolescent sexual and reproductive health education into the syllabus of all learning institutions was never implemented. It was hoped that through this document, knowledge of awareness in reference to utilization of maternal health care services among women within childbearing age would be enhanced.

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## **APPENDICES**

### **APPENDIX 1: Letter of Introduction by the Researcher to the Respondents**

Dear participant,

My name is Paschalia Mbutu from University of Nairobi. I am a PhD student. Currently I am conducting a research on Women's Perspectives on Choice of Place of Delivery during Pregnancy in Kenya: A case of Kitui West, Kitui County.

I kindly request you to participate in this research. Please feel free to participate because your views will be treated with confidentiality. Besides, your names will be coded to conceal identity. Your participation will be voluntary.

Thank you,

Paschalia Mbutu

## APPENDIX 2: Interview Guide for ANC-Attendees and Non-Attendees

### Section I: Personal Details of the Pregnant Woman

Name of Facility.....

Interview date.....

Respondent number.....

Name of respondent.....

Contact of respondent .....

Village.....

1. What is your age?.....

2. What is your marital status?.....

3. What is your level of education?.....

4. What is your religion?.....

5. What is your occupation?.....

### Section II

1. What is the gestation period of pregnancy (in months)?.....

2. What is the number of your previous deliveries?.....

3. What is the number of your previous children delivered at home?.....

3b. What were the reasons for choosing to deliver at home?.....

4. What is the number of your previous children delivered in a health facility?.....

4b. What were the reasons for choosing to deliver in a health facility?.....

5. Do you have any children who have died during childbirth?.....

6. Where were they born, was it at home or in a health facility? .....

7. What was the cause of the death?.....

8. Any complications experienced during previous childbirth? Explain.....

9. Where are you planning to deliver the baby? Explain.....

10. Before you choose your place of delivery, is it necessary to seek for permission from anyone? Explain.....

11. Are you aware of any complications that can occur to a pregnant woman during child birth? Explain.....

12. Are you aware of any complications that can occur to a baby during child birth? Explain.....

.....

13. Does choosing to deliver in a health facility or at home depend on the pregnant woman's level of income? Explain .....
14. Are you aware of any advantages of delivering in a health facility? Explain.....
15. Does age determine whether a pregnant woman will choose to deliver her baby at home or in a health facility? Explain.....
16. Are cultural beliefs and practice likely to influence your choice of place of delivering your baby? Explain.....
17. Do your religious beliefs and practices influence your choice of place of deliver? Explain.....
18. Can lack of transport influence your choice of place of delivery? Explain.....
19. Does your occupation influence your choice of place of delivery?.....

### **APPENDIX 3: FGD Guide**

Name of facility

Interview date

1. Do pregnant women ask permission before choosing place of delivery?
2. Are you aware of complications that can occur during childbirth?
3. Does choosing to deliver in a health facility or at home depend on the pregnant woman's level of income?
4. Does age determine whether a pregnant woman will choose to deliver her baby at home or in a health facility?
5. Can cultural beliefs and practice influence choice of place of delivery for a pregnant?
6. Can religious beliefs and practices influence choice of place of delivery for a pregnant woman?
7. Can lack of transport influence choice of place of delivery for a pregnant woman?
8. Does occupation influence choice of place of delivery for a pregnant woman?

## **APPENDIX 4: TBAs Interview Guide**

Date of interview

1. Is there a time a pregnant woman plans to deliver in a health facility but later chooses to deliver at home?
2. Can a pregnant woman deliver in a health facility against her husband's wish to deliver at home?
3. Does the anticipated gender of a baby influence the pregnant woman's choice of place of delivery?
4. Do you have prior link with pregnant women who come for delivery?
5. Are you aware of any problems that can occur during childbirth?
6. What happens in the event that the pregnant woman cannot deliver at home?
7. Do you give any advice about childbirth to pregnant/postnatal women when they come to see you?
8. In case there is a problem during labour or after delivery and family members are reluctant to take action, can you intervene?
9. What do pregnant women say about delivering babies in a health facility?
10. Are you aware of pregnant women's reproductive rights?
11. Which category of women is likely to deliver at home and why?
12. Do you have any connection with nurses regarding your role as a TBA?



## **APPENDIX 5: Nurses Interview Guide**

### Place of interview

1. Do you think there are times a pregnant woman plans to deliver in a health facility but later chooses to deliver at home?
2. Does the anticipated gender of a baby influence choice of place of delivery for the woman?
3. Do you interact in any way with TBAs?
4. Which category of pregnant women is likely to deliver in a health facility and why?
5. Are the pregnant women aware of their reproductive rights?
6. What do pregnant women say about delivering in a health facility?
7. If a pregnant woman was being attended by a TBA all through and only comes for delivery in a health facility, would she be assisted?
8. Is there a government policy regarding what a TBA should know?

## **APPENDIX 6: Interview Guide - Postnatal Women**

Date of interview

- A. Where did you eventually deliver your baby?
- B. Was the place of delivery different from the place you had planned to deliver?
- C. Reasons for change of place of delivery if applicable
- D. If you knew the baby's gender before delivery would you have changed place of delivery?

## APPENDIX 7: Chi-Square Test Analysis: ANC-Attendees

Study Variable	Home delivery	Health facility delivery	Health facility/not identified	$\chi^2$	df	p
<b>Age</b> Below 25 years Above 25 years	3.7% 9.3%	91.4% 90.7%	4.9% 0.0%	4.356	2	<b>0.045</b>
<b>Education level</b> No formal education Primary Secondary and above Tertiary	6.0% 6.4% 5.8%	91.0% 89.4% 91.9%	3.0% 4.3% 2.3%	0.617	4	<b>0.961</b>
<b>Religion</b> Catholic Other religions	2.2% 7.8%	93.3% 90.0%	4.4% 2.2%	2.099	2	<b>0.350</b>
<b>Marital status</b> Married Unmarried	5.8% 6.2%	93.2% 84.4%	1.0% 9.4%	6.036	2	<b>0.049</b>
<b>Previous safe deliveries</b> 1st pregnancy 1-2 deliveries 3 and above deliveries	4.2% 7.9% 4.5%	91.7% 88.9% 95.5%	4.2% 3.2% 0.0%	1.701	4	<b>0.044</b>
<b>Occupation</b> House wife No occupation Small businesses Subsistence farming Teaching	3.8% 0.0% 5.0% 8.2% 5.9%	84.6% 100.0% 95.0% 91.8% 91.1%	11.5% 0.0% 0.0% 0.0% 3.0%	14.012	14	<b>0.449</b>
<b>Cultural practices &amp; belief</b> Culture influences Culture does not influence	0.0% 6.5%	100% 90.2%	0.0% 3.3%	1.285	2	<b>0.526</b>
<b>Awareness of complications—mother</b> Aware of complications Not aware of complications	5.8% 6.1%	90.7% 91.8%	3.5% 2.0%	0.230	2	<b>0.891</b>
<b>Awareness of complications—child</b> Aware of complications Not aware of complications	9.5% 5.9%	89.2% 91.1%	1.4% 3.0%	4.953	2	<b>0.084</b>
<b>Advantages of health facility delivery</b> In case of complications Care given Medical professionalism Special case	1.8% 27.3% 25.0% 5.9%	94.7% 72.7% 75.0% 91.1%	3.5% 0.0% 0.0% 3.0%	14.018	8	<b>0.081</b>
<b>Access to health facility</b> Transport influences Transport does not influence	5.9% 6.0%	91.1% 91.0%	3.0% 3.0%	0.198	2	<b>0.906</b>

APPENDIX 8: Chi-Square Test Analysis: Non-ANC-Attendees

<b>Study Variable</b>	Home delivery	Health facility delivery	Health facility delivery/ not identified	$\chi^2$	df	p
<b>Education level</b>				4.612	4	<b>0.330</b>
No formal education	50.0%	50.0%	0.0%			
Primary	61.9%	9.5%	28.6%			
Secondary	71.4%	0.0%	28.6%			
<b>Religion</b>				1.259	2	<b>0.533</b>
Catholic	75.0%	12.5%	12.5%			
Other religions	57.1%	9.5%	33.4%			
<b>Marital status &amp; age</b>				2.918	2	<b>0.232</b>
Married	54.5%	13.6%	31.8%			
Unmarried	87.5%	0.0%	12.5%			
<b>Previous safe deliveries</b>				1.080	4	<b>0.028</b>
1st pregnancy	75.0%	0.0%	25.0%			
1-2 deliveries	70.0%	10.0%	20.0%			
3 and above deliveries	56.2%	12.5%	31.3%			
<b>Occupation</b>				9.633	8	<b>0.292</b>
Farming	66.7%	33.3%	0.0%			
House wife	50.0%	0.0%	50.0%			
Small businesses	50.0%	7.1%	42.9%			
Subsistence farming	83.3%	16.7%	0.0%			
<b>Cultural practices &amp; belief</b>				0.545	2	<b>0.761</b>
Culture influences	64.3%	10.7%	25.0%			
Culture does not influence	65.5	10.3	24.1			
<b>Awareness of complications –mother</b>				4.352	2	<b>0.113</b>
Awareness of complications influences	75.0%	10.0%	15.0%			
Awareness of complications Does not influence	63.3%	10.0%	26.7%			
<b>Awareness of complications –child</b>				0.599	2	<b>0.741</b>
Complications after delivery	62.1%	10.3%	27.6%			
Baby with swollen head	63.3%	10.0%	26.7%			
<b>Access to health facility</b>				0.395	2	<b>0.821</b>
Transport influences	10.0%	90.0%	0.0%			
Transport does not influence	6.8%	90.4%	2.7%			